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# Montana State Plan For

# ALCOHOLISM

and

# ALCOHOL

# ABUSE

## fiscal year 1977

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MONTANA STATE PLAN FOR ALCOHOL ABUSE AND  
ALCOHOLISM PREVENTION, TREATMENT AND REHABILITATION PROGRAMS

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PREFACE

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THE MONTANA STATE PLAN PRESENTS A COORDINATED,  
COMPREHENSIVE PROGRAM FOR THE ORDERLY DEVELOP-  
MENT AND IMPLEMENTATION OF NEEDED ALCOHOLISM  
PREVENTION, TREATMENT AND REHABILITATION PRO-  
GRAMS FOR THE ENTIRE STATE OF MONTANA.

SUBMITTED BY: MONTANA DEPARTMENT OF INSTITUTIONS  
LAWRENCE M. ZANTO  
DIRECTOR

ALCOHOL AND DRUG ABUSE DIVISION  
MICHAEL A. MURRAY  
ADMINISTRATOR

COMMUNITY & PROGRAM DEVELOPMENT BUREAU  
GEORGE L. SWARTZ  
CHIEF

REPORTING AND EVALUATION BUREAU  
ROBERT W. ANDERSON  
CHIEF

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## SECTION 1

INTRODUCTION

COORDINATION WITH OTHER STATE AGENCIES

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MINORITY REPRESENTATION STATEMENT

ASSURANCES

LETTER OF ACCEPTANCE - HEALTH EDUCATION & WELFARE

A-95 REVIEW AND COMMENT

HSA AND HEALTH COOPERATION DOCUMENTATION

PROOF OF AVAILABILITY FOR PUBLIC REVIEW (30 DAYS)

STATE PLAN FOR  
ALCOHOL ABUSE AND ALCOHOLISM PREVENTION,  
TREATMENT AND REHABILITATION

DEPARTMENT OF INSTITUTIONS

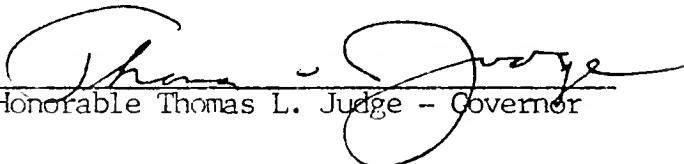
(Designated Administrative Agency for the  
Comprehensive Alcohol Abuse and Alcoholism  
Prevention, Treatment and Rehabilitation  
Act of 1970)

Lawrence M. Zanto  
(Director)

Honorable Thomas L. Judge  
(State Chief Executive Officer)

Public review period July 20, to August 20, 1977

Certification for Approval

  
Honorable Thomas L. Judge - Governor

INTRODUCTION

The following Montana State Plan for Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation is presented toward fulfilling the requirements of the comprehensive alcohol abuse and alcoholism prevention treatment and rehabilitation act of 1970 (P.L. 91-616) and as amended by Public Law 93-282. The Montana State Plan is a public document that presents a coordinated comprehensive program for the orderly development and implementation of needed alcoholism prevention, treatment and rehabilitation programs for the entire State of Montana.

It serves as a basis for the allocation of formula grant funds and provides the rationale and effective basis for the utilization of federal, state and all other available resources in planning and establishing, maintaining, coordinating and evaluating prevention, treatment and rehabilitation projects and programs to deal with alcohol abusers and alcoholism in the State of Montana. This State Plan will facilitate the acquisition of necessary funds, assist in gaining other types of needed support, allow the state and localities to set appropriate and realistic goals and priorities, provide a useful tool for evaluation, assist in community education and contribute to total state growth and development.

## COORDINATION WITH OTHER STATE AGENCIES

Many state agencies have responsibility for certain aspects of the total alcoholism service delivery system. The Department of Institutions has the major role but other state departments have specific functions.

Working relationships have been developed with the Department of Health and Environmental Sciences, Social and Rehabilitative Services, the Department of Community Affairs, the Department of Justice, and the Department of Public Instruction.

The coordination of effort between the several state agencies is viewed by the Single State Alcoholism Authority as an on-going and continuous process. Efforts are made, whenever possible, to involve other departments in the development of services and the delivery to the alcoholics and alcohol abusers in the communities.

The state agencies of Montana are continuing to adjust their coordination with other agencies as a result of the Executive Reorganization. This reorganization, that has been implemented, has altered the existing relationships between state departments and most state departments are still working toward a total and complete readjustment. The duties and functions of the departments have changed and as a result, the coordination that has existed for years is currently being restructured.

Coordination of all alcoholism services is viewed as a long term function that involves many of the state departments. This department intends to create every opportunity for meaningful involvement of every other state department having a role or function in the delivery of services to the alcoholic or alcohol abuser throughout the state.

Efforts have also been made to coordinate with the federal agencies having a role or function in the alcoholism service delivery system operating in Montana.

## PURPOSE

Under delegated authority from the director, Department of Institutions, the Alcohol and Drug Abuse Division will act as the Single State Authority for programs of alcoholism. With that responsibility the Alcohol and Drug Abuse Division will: 1. review, evaluate, and coordinate all federal and state funding proposals relating to alcohol abuse, 2. develop and review annually a State Plan for Alcoholism with all programs reviewed in terms of regional plan and this State Plan. All efforts and programs of the Division will encourage the development of coordinated community regional and statewide programs with the broadest possible citizen involvement.

Public and private support will be sought so that the Division's role will be that of initiator and catalyst rather than that of the maintainer of programs.

The Plan follows the guidelines for the preparation of State Alcohol Plans which was submitted to the Montana Department of Health and Environmental Sciences by W. Claude Reeder, National Institute of Alcohol and Alcohol Abuse, and received in 1972.

## PHILOSOPHY

A service philosophy for alcohol and drug programs alike has been developed. This philosophy, while not complex, will provide an opportunity to measure the qualitative effectiveness of our services - a long needed attribute. Our mission will be to increase the frequency of client participation in socially acceptable, productive activity as an alternative to dysfunctional abuse of alcohol or other addictive drugs. To measure accomplishment of this mission, we have outlined three



measurable treatment objectives:

1. To reduce the number of drop-outs from our treatment programs.
2. To increase the frequency of contact between clients and program services.
3. And finally, to develop less client dependence on alcohol, drugs and our programs by increasing client participation in training/education, employment and community activities.

## ALCOHOLICS IN MONTANA

Estimates of the number of alcoholics in the general population vary between the several sources of information. Dr. Morris Chafetz, former Director of the National Institute on Alcohol Abuse and Alcoholism, used the figure of five percent of the general population. This would indicate that there are some 34,720 alcoholics in Montana. He also indicates that the incidence of alcoholism among Indians varies from ten percent to fifty percent. Montana has seven Indian reservations that together constitute 4.2 percent of the state population. A projected figure of Indian alcoholism in Montana would substantially increase the State total of alcoholic persons. The Social Research Group at George Washington University uses a figure of 8.15 percent of the general population. This would show 56,663. They do not make special reference to Indians.

All of the indications of alcohol consumption, alcohol related accidents, and other indicators are apparently showing increases; for example, the per capita consumption in Montana is showing an annual increase that is only surpassed by three other states. As a result, the percentage of alcoholics in Montana would be substantially figure upward to 8.50% for planning purposes. This then gives the following estimates:

8.5% of population (except Indian) . . . . .	57,902
50% of Indian Population . . . . .	13,565
Total . . . . .	71,467
Ripple effect, others affected -----	285,868

The number of alcoholics and alcohol abusers in Montana are not known at this time. The above mentioned indicators are only estimates based on available information.

Various portions of the problems related to alcoholism and alcohol abuse have been described in many ways. The following brief but impressive listing focuses on the total impact that is felt by every community in Montana. (Cit. ALCOHOLISM DIGEST, Vol. V, No. 4):

- There are more than 9 million alcoholics nationwide.
- Alcoholism, in some way, affects an estimated 45 million people.
- Nearly 500,000 teenagers are alcoholics.
- About 3 million women are addicted to alcohol.
- Five to 10 percent of the nation's workers are alcoholics, costing industry an estimated \$10 billion annually.
- There are some 28,000 alcohol-related highway fatalities annually.
- Fifty percent of all homicides are alcohol-related.
- Fifty-five percent of all arrests are alcohol-related, with many involving violent crimes such as sexual assaults on women and children, stabbings, beatings and shootings.
- Forty percent of the patients in any given hospital are alcoholics.
- Seventy percent of the Army's enlisted men and 36 percent of the officers are either problem drinkers or heavy drinkers.

- Alcoholism is the number one problem among American Indians, affecting the group five times worse than non-Indians.
- Alcohol plays a major part in various deaths, injuries and accidents, including snowmobile accidents, burns, drownings, accidental poisonings, fire deaths, home and fatal aircraft accidents.
- Alcohol misuse has been implicated in the development of certain cancers.
- Alcohol abuse by pregnant, alcoholic mothers may negatively affect their offspring.
- The liver, heart, brain and other parts of the body may be adversely affected by alcohol abuse.
- And so on - - -

These statistics and impressions present the national impact related to alcoholism and alcohol abuse, however, Montana continues to be a "Heavy Drinking" state and ranks fourth highest in the nation in per capita consumption of alcoholic beverage. The impact is significant.

#### Trends in Adolescent Drinking Behavior

In an effort to discover the nature of drinking behavior among adolescents, a national survey was undertaken by the Center for the Study of Social Behavior for the National Institute on Alcohol Abuse and Alcoholism. The final report of April, 1975 states that about 74 percent of the adolescent population (national probability sample of all Junior and Senior High School students in grades 7-12 in the contiguous 48 states and the District of Columbia) have had a drink more than two or three times in their lives. Of the adolescents surveyed, one-half of whom are under 16 years of age, 54.8 percent drink once a month or more

often and another 23.3 percent drink once a week or more often, with beer being the most frequently chosen beverage. On various scales to indicate problem drinking, the adolescents rank as follows:

- Almost 1 out of 4 (24.1 percent) report having been drunk 4 or more times during the previous year. This frequency for drunkenness is 3 or 4 times greater than for all drinkers.

- In reporting negative consequences of drinking, 17.1 percent of the youths mentioned difficulties with friends and 10.4 percent cited criticism from dates as a result of their drinking. Trouble with police was mentioned by 7 percent of the respondents and trouble with school personnel by 4.9 percent.

- 40 percent of the students reported drinking in cars and 15.9 percent reported driving after having had a "good bit to drink".

- 35 percent of the students said they drink alone at least sometimes.

- 2.5 percent judged their drinking to be a "considerable" or "serious" problem while 9.8 percent stated they found their drinking to be a "mild" problem.

As in studies conducted at the local level, this national survey indicates that boys drink with greater frequency and in greater quantities than girls. However, there appears to be a noticeable shift toward more adolescent girls drinking alcoholic beverages than in previous samples.

As expected, the quantity and frequency of alcohol consumption increases with age. A dramatic shift between abstainer and drinker occurs from age 13-17.

White adolescents have the highest proportion of drinkers and Blacks the smallest proportion. American Indian youth have the highest proportion of heavy drinkers (as defined in this survey, heavy drinkers drink at least once a week and 5-12 drinks per occasion) (16.5 percent) followed by Orientals (13.5 percent), Spanish (10.9 percent), whites (10.7 percent) and Blacks (5.7 percent).

Drinking levels vary little by region of the country, and though some research indicates drinking levels vary inversely with urbanization levels, such differences did not show up significantly in the present study.

It should be noted that these data do not include high school dropouts, and studies indicate the dropout population has a higher proportion of drinkers than the in-school population. The levels of alcohol consumption by teenagers is probably underestimated because of this.

Statistics describing the consumption of alcoholic beverages by the youth of Montana are not available, however, it is reasonable to assume that the youth of this state make a substantial contribution to the state's rank as fourth highest in per capita consumption.

#### Minority Representation

The significant minority residing in Montana is made up of native Americans residing on the seven (7) reservations and also native Americans residing in the urban areas of the State. The Regional Addictive Disease Resource Development Specialists have solicited input from both the native Americans residing on the reservations and those residing in the urban areas and this native American input is incorporated into the regional plans.

## ASSURANCES

MAINTENANCE OF EFFORT. The State of Montana hereby provides assurance that Federal funds will not supplant non-Federal funds that may be otherwise available for provision of the services and carrying out the activities under this Plan. Such funds will, to the extent practical, be used to increase the level of funds otherwise available for such services and activities.

MERIT SYSTEM. The Alcohol and Drug Abuse Division of the Montana Department of Institutions is a participating agency in the Montana State Merit System Plan. This Plan is developed and administered in accordance with "Standards for a Personnel Merit System", 45 EPR, Part 70.

NONDISCRIMINATION. All services provided under this State Plan will be made available without discrimination on account of race, creed, color, sex, marital status, or duration of residence.

The Department of Institutions and any other agency, organization, or institution carrying out any authority under the State Plan shall not discriminate in any way against any employee with respect to compensation, terms, conditions, or privileges of employment solely because of race, color, creed, sex, or national origin, nor shall they refuse employment to any qualified applicant for a position solely on the basis of the fact that he or she has or has not had a problem of alcohol abuse or alcoholism.

No formula grant funds will be awarded to public or private general hospitals which have received Federal funds for alcoholic treatment programs and which refuse admission and treatment to alcoholic persons solely on the basis of their alcoholism.

NO CONFLICT OF INTEREST. No employee of the Department of Institutions nor any firm, organization, or corporation receives funds from any applicant directly or indirectly in payment for services provided in connection with the Montana State Plan for Alcohol Abuse and Alcoholism. Applicant agencies requesting subgrant funds will be required to submit a similar assurance.

ACCOUNTING PROCEDURES. Accounting procedures necessary to assure proper disbursement of and accounting for funds paid to the State under this formula grant program have been established by the Management Services Division of the Department. Funds allocated to Montana in the Alcohol formula grant program under Public Law 91-616 will be clearly delineated from those obtained under other Federal formula or project grant programs. To this point, the budget number for this program has been established as 04571, Alcoholism Grant Program, for fiscal control purposes.

All records will be kept for such periods of time as deemed necessary for completion of Federal Audit as specified in the Guidelines for the Formula Grant Program under Public Law 91-616 and amendments.

Fiscal records relative to the use of funds made available under Public Law 91-616 and amendments shall be made available to inspection and fiscal audit at reasonable times by persons designated by the Secretary.

REPORTS. Annual progress and expenditure reports shall be submitted as may be required, to the Associate Regional Health Director, Department of Health, Education, and Welfare, Region VIII, Denver, with a copy to the Director of the National Institute on Alcohol Abuse and Alcoholism.



ACCESSIBILITY. All the services provided under this plan will be so publicized as to be generally known to the population to be served, and will be available and responsive to the needs of those to be served, and will be so located as to be readily accessible to the population to be served.

SUBMISSION, REVIEW, AND APPROVAL OF THE STATE PLAN. The State Plan will be reviewed and updated or revised as necessary, at least annually. The Plan will be modified during the year if such modification is deemed necessary, and also as new or revised data or information is available. Any revisions or updating will be subject to the same review procedure as the plan itself.

In years subsequent to this submission, the procedure to be followed in the submission and review of the plan will be as follows;

As soon as possible following submission of the plan for a fiscal year, staff revision and updating of the document will begin. The plan for fiscal year 1978 will be developed and prepared for review by the Advisory Council as early in the fiscal year as is practical.

Following Council review and comments, the documents will be made available for public review and comment at the Executive Office of the Department of Institutions, 1539 11th Avenue, Helena, Montana, as well as the office of the Alcohol and Drug Abuse Division of the Department. Such availability will be announced through a description of the plan and a notice of its availability, which will be published 30 days prior to submission for approval.

Following this 30 day review period, copies will be submitted to the Office of the Governor, A-95 Clearinghouse for their review and comments relative to the relationship of this plan or any modifications

of the plan to comprehensive and other State plans and programs and will provide the Department of Health, Education, and Welfare with their comments.

Forty-five days will be allocated for such review, and any comments or statements that there are no comments will be submitted with the plan.

#### Nondiscrimination

That all services provided under the State Plan will be made available without discrimination on account of sex, duration of residence or ability or inability to pay for such services. In addition, Title VI of the Civil Rights Act of 1964 (42 USC 2000d; 78 Stat. 252), which provides that no person in the United States shall, on the ground of race, color, creed, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance, is applicable to services and programs provided under the State Plan.

That no formula grant funds will be awarded to public or private general hospitals which have received Federal funds for alcoholic treatment programs and which refuse admission and treatment to alcoholic persons solely on the basis of their alcoholism.

#### Evaluation

The prevention education or treatment projects or programs supported by formula, or state grant funds have and will continue to provide the Alcohol and Drug Abuse Division a proposed performance standard or standards to measure, or research protocol to determine, the effectiveness of such prevention or treatment programs or projects.

All of the other required assurances as described in previous State Plans are being met by this FY 76 Plan.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGION VIII

FEDERAL OFFICE BUILDING  
19TH AND STOUT STREETS  
DENVER, COLORADO 80202

SEP 27 1977

PUBLIC HEALTH SERVICE

Mr. Lawrence Zanto, Director  
Montana State Department of Institutions  
Bureau of Addictive Diseases  
1539 11th Avenue  
Helena, Montana 59601

Re: Montana State Plan for Alcohol and  
Alcohol Abuse, FY 1977

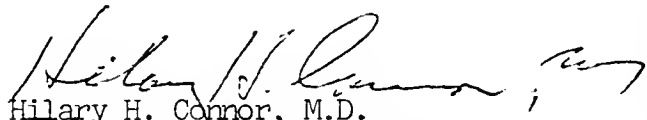
Dear Mr. Zanto:

This letter constitutes full approval of the State Plan for Alcohol and Alcohol Abuse - FY 1977. The award will be in the amount of \$200,000.

Noteworthy aspects of the Plan include: increase in state-wide service impact, progress in certification and involvement of Indian alcoholism programs. Montana is commended for research efforts undertaken.

Good wishes for continued progress in establishing effective alcohol services for residents of the State of Montana.

Sincerely yours,

  
Hilary H. Connor, M.D.  
Regional Health Administrator

cc: Claude Reeder (2)  
Grants Management

RECEIVED

SEP 29 1977

STATE DEPT. OF INSTITUTIONS

Office of the Governor

## Budget and Program Planning

Capitol Building - Helena, Montana 59601

Thomas L. Judge  
Governor

Michael G. Billings  
Director

August 29, 1977

Mr. Mike Murray  
Addictive Diseases Bureau  
Department of Institutions  
1539 11th Avenue  
Helena, Montana 59601

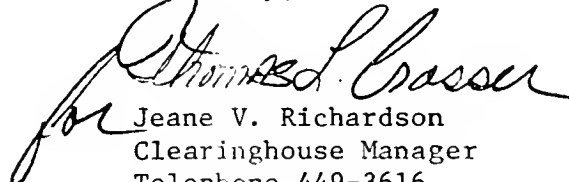
Dear Mr. Murray:

Re: A-95 Clearinghouse Signoff 77-08-11

The Montana State Clearinghouse has changed the review status on the above application from block two to block one. All comments from reviewing agencies were favorable.

You may send the original of this letter to your federal funding agency contact person and keep the enclosed copy for your files.

Sincerely,

  
for Jeane V. Richardson  
Clearinghouse Manager  
Telephone 449-3616

JVR:cm



# Montana Health Systems Agency, Inc.

324 Fuller Avenue  
Helena, Montana 59601

406 443-5965

Ralph Gildroy  
Executive Director

July 22, 1977

Michael A. Murray, Chief  
Addictive Diseases Bureau  
Department of Institutions  
State of Montana  
1539 Eleventh Avenue  
Helena, Montana 59601

Dear Mike:

This letter is to thank you wholeheartedly in helping us prepare components on alcohol and drug abuse in the Health Systems Plan (HSP) which will be based on your agency's areawide alcohol and drug abuse plans.

Your cooperation in setting up the HSA process to review future alcohol treatment programs is also greatly appreciated. We believe that these reviews will give area residents a voice in determining where these facilities should be located and thus bring government back to its constituency.

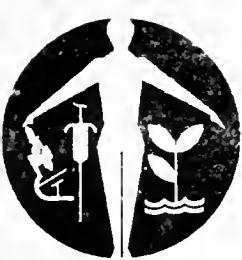
We look forward to working closely with you in the future. Thanks.

Sincerely,

*Ralph Gildroy*

RALPH GILDROY, Executive Director  
Montana Health Systems Agency, Inc.

RG:pr



Department of Health and Environmental Sciences  
STATE OF MONTANA HELENA, MONTANA 59601

July 21, 1977

~~John S. Anderson M.D.~~  
~~Director~~

A.C. Knight, M.D.  
Director

Mr. Mike Murray, Administrator  
Alcohol and Drug Abuse Division  
Department of Institutions  
Capitol Station  
Helena, Montana 59601

Dear Mike:

This letter is to confirm that the staffs of the State of Montana Alcohol and Drug Abuse Division and the Department of Health and Environmental Sciences, Bureau of Health Planning and Resource Development, have worked together in the development of the Montana State Alcohol Plan for FY 78. It is my opinion that the planning methodologies involved fulfill the intent of PL 93-641.

It is the intent of the Bureau of Health Planning and Resource Development to summarize the basic content of the alcohol plan submitted by the Alcohol and Drug Abuse Division for incorporation into the Montana State Health Plan. I am encouraged by the spirit of cooperation related to the planning process that has been begun this year. I am certain that major progress has been made toward aligning the various health policies of the State with the goals and objectives as outlined in the Montana State Health Plan.

Sincerely,

A.C. Knight, M.D., F.C.C.P.  
Director

ACK:LM:dd





## SECTION 2

### 2.1 LEGAL REFERENCES

### 2.2 CHAPTER 27, R.C.M. 1947

### 2.3 MONTANA ADMINISTRATIVE CODE - TITLE 20, CHAPTER 3



MONTANA STATE PLAN FY 76

LEGAL REFERENCES

REVISED CODES OF MONTANA  
TITLE 80 - STATE INSTITUTIONS  
CHAPTER 27 - ALCOHOL AND DRUG DEPENDENCE

- 80-2701. Purpose of intent of act -- policy of state.
- 80-2702. Duties of department--department authorized to accept--gifts--enter into contracts--acquire and dispose of property.
- 80-2703. Administration of federal program.
- 80-2704. Receipt of financial assistance authorized--cooperation with other agencies and organizations.
- 80-2705. Department to administer act.
- 80-2706. State and local government to cooperate with the department--not subject to its control.
- 80-2707. Deposit of funds from federal or private sources with state treasurer.
- 80-2708. Declaration of policy.
- 80-2709. Definitions.
- 80-2710. Powers of department.
- 80-2711. Duties of department.
- 80-2712. Comprehensive program for treatment.
- 80-2713. Facility standards--inspections--approvals.
- 80-2714. Acceptance for treatment--rules.
- 80-2715. Voluntary treatment of alcoholics.
- 80-2716. Treatment and services for intoxicated persons and persons incapacitated by alcohol.
- 80-2717. Emergency commitment.
- 80-2718. Involuntary commitment of alcoholics.
- 80-2719. Records of alcoholics and intoxicated persons.
- 30-2720. Visitation and communication of patients.
- 80-2721. Application of Administrative Procedure Act.
- 80-2722. Departmental reports to legislature.
- 80-2723. Criminal laws limitations.
- 80-2724. Public intoxication not criminal offense.
- 80-2725. State-approved alcoholism programs utilizing funding generated by taxation on alcoholic beverages.

Montana Administrative Code, Volume 4, Part I, Title 20, Chapter 3.

FEDERAL STATUTES:

P.L. 91-616, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.  
Title III, (84 STAT. 1849)  
Sec. 303 (84 STAT. 1850)  
Sec. 311 (84 STAT. 1851)

P.L. 93-282, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974.  
Sec. 111 (88 STAT. 129)

REVISED CODES OF MONTANA

Chapter 27

ALCOHOL AND DRUG DEPENDENCE

80-2701. **Purpose and intent of act - policy of state.** It is the purpose of this act and the policy of this state to recognize alcohol and drug dependence as problems affecting the health, safety, morals, economy, and general welfare of this state; to recognize alcohol and drug dependence as problems subject to treatment; and to recognize the sufferer of alcohol, drug dependence, or both, as worthy of treatment and rehabilitation. It is the intent of this act to establish means whereby the appropriate resources of this state may be focused fully and effectively upon the problems of alcohol and drug dependence and utilized in implementing programs for the control and treatment of these problems.

80-2702. **Duties of department - department authorized to accept gifts - enter into contracts - acquire and dispose of property.** (1) The department of institutions, hereafter referred to as department in this chapter, shall:

(a) Plan, promote, and assist in the support of alcohol and drug dependence prevention, treatment, and control programs;

(b) Conduct, sponsor, and support research, investigations, and studies, including evaluation, of all phases of alcohol and drug dependence;

(c) Assist the development of educational and training programs relative to alcohol and drug dependence, and carry on programs to assist the public, and technical and professional groups, in becoming fully informed about alcohol and drug dependence;

(d) Promote, develop, and assist financially and otherwise, alcohol and drug dependence programs administered by other state agencies, local government agencies, and private nonprofit organizations and agencies;

(e) Encourage and promote effective use of facilities, resources, and funds in the planning and conduct of programs and activities for prevention, treatment, and control of alcohol and drug dependence and, in this respect, co-operate with and utilize to the maximum possible extent the resources and services of federal, state, and local agencies.

(2) To carry out this act, the department may:

(a) Accept gifts, grants, and donations of money and property from public and private sources;

(b) Enter into contracts;

(c) Acquire and dispose of property.

[History: 69-6203 - amend commission to department.]

80- 2703. **Administration of federal program.** The department of institutions is hereby designated the single state agency for the administration of federal programs under:

(1) the Drug Abuse Office and Treatment act of 1972, Public Law 92-255 as amended, 21 U.S.C. section 1176; and

(2) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Public Law 91-616 as amended, 42 U.S.C. section 4573.

[History: Enacted 80-2703 by Section 4, Chapter 280 L. 1975.]

Note: Section 5, Chapter 280, Laws 1975 provides: "The provisions of sections 82A-116 through 82A-122 are applicable to this act."

**82A-116. Rights of state personnel.** Unless otherwise provided in this act, each state officer or employee affected by the reorganization of the executive branch of state government under this title is entitled to all rights which he possessed as a state officer or employee before the effective date of the applicable chapter of this title, including rights to tenure in office and of rank or grade, rights to vacation and sick pay and leave, rights under any retirement or personnel plan or labor union contract, rights to compensatory time earned, and any other rights under any law or administrative policy. This section is not intended to create any new rights in effect before the effective date of the applicable chapter of this title or an amendment to this title.

[History: Enact 81A-116 by Section 1, Chapter 272, L. 1971; amend Section 14, Chapter 358, L. 1973.]

[Amendments: The 1973 amendment substituted "branch" for "department" near the beginning; substituted "this title" for "this act" in three places; and added "or an amendment to this title" at the end of the section.]

**82A-117. Rights to property.** The department or unit thereof that succeeds to all or part of the functions of an agency under this title also succeeds to the rights to all real and personal property of that agency relating to the functions or parts of functions transferred. The property includes real property, records, office equipment, supplies, contracts, books, papers, documents, maps appropriations, accounts within and without the state treasury, funds, vehicles, and all other similar property. However, the department or unit may not use or divert moneys in a fund or account for a purpose other than provided by law. The governor shall resolve any conflict as to the proper disposition of the property, and his decision is final. This section does not apply to property owned by the federal government.

[History: Enacted 82A-117 by Section 1, Chapter 272, L. 1971; amended Section 15, Chapter 358, L. 1973.]

[Amendments: The 1973 amendment substituted "this title" for "this act" in the first sentence.]

**82A-118. Rules, regulations and orders.** The department or unit thereof that succeeds to all or part of the functions of an agency under this title also succeeds to the rules, regulations, and orders of that agency relating to the functions or parts of functions transferred. The rules, regulations, and orders of any agency in effect before the effective date of the transfer remain in effect until amended, repealed, superceded, or nullified by proper authority or by law.

History: Enacted 82A-118 by Section 1, Chapter 272, L. 1971; amended Section 16, Chapter 358, L. 1973.

Amendments: The 1973 amendment substituted "this title" for "this act" in the first sentence; and substituted "transfer" for "chapter affecting the agency" in the second sentence.

**82A-119. Legal proceedings.** The transfer or abolition of an agency or function under this title does not affect the validity of any judicial or administrative proceeding pending or which could have been commenced before the effective date of the transfer or abolition, and the department or unit which succeeds to the functions of an agency relating to the proceeding shall be substituted as a party in interest.

History: Enacted 32A-119 by Section 1, Chapter 272, L. 1971; amended Section 17, Chapter 358, L. 1973.

Amendments: The 1973 amendment inserted "The transfer or abolition of an agency or function under" at the beginning of the section; substituted "this title" for "this act"; and substituted "transfer or abolition" for "applicable chapter of this act."

**82A-120. Rights and duties under existing transactions.** The rights, privileges, and duties of the holders of bonds and other obligations issued, and the parties to contracts, leases, indentures, and other transactions entered into, before the effective date of the transfer of functions under this title, by the state or by any agency, officer, or employee thereof, and covenants and agreements as set forth therein, remain in effect, and none of those rights, privileges, duties, covenants, or agreements is impaired or diminished by reason of the transfer of the functions of an agency or the abolition of an agency under this title. The department or unit which succeeds to the functions of an agency is substituted for that agency and succeeds to its rights and duties under the provisions of those bonds, contracts, leases, indentures, and other transactions.

History: Enacted 82A-120 by Section 1, Chapter 272, L. 1971; amended Section 18, Chapter 358, L. 1973.

Amendments: The 1973 amendment substituted "transfer of functions under this title" for "applicable chapter of this act" in the first sentence; and substituted "under this title" for "in this act" at the end of the first sentence.

**82A-121. References.** Unless consistent with this title, if an agency is abolished under this title, or if a function of an agency is transferred to another agency, references to the abolished agency or to the agency whose functions were transferred in any law, contract, or other document shall apply to the agency which succeeds to the functions which were transferred.

History: Enacted 82A-121 by Section 1, Chapter 272, L. 1971; amended Section 19, Chapter 358, L. 1973.

Amendments: The 1973 amendment completely rewrote this section and made it applicable to abolition of agencies or transfer of functions at any time rather than those made by the 1971 reorganization.

82A-122. Federal aid. If any part of this title is ruled to be in conflict with federal requirements which are a prescribed condition to the receipt of federal aid by the state, an agency, or a political subdivision, that part of this title has no effect, and the governor may issue an executive order which substitutes for that part to the extent necessary to effectuate the receipt of federal aid. The order is effective until the legislative assembly again acts upon the matter.

History: Enacted 82A-122 by Section 1, Chapter 272, L. 1971; amended Section 20, Chapter 358, L. 1973.

Amendments: The 1973 amendment substituted "title" for "act" twice in the first sentence.

Repealing Clauses: Section 3 of Chapter 272, Laws 1971 read "Sections 59-901 and 59-902, R.C.M. 1947, are repealed."

Section 21 of Chapter 358, Laws 1973 read "Sections 82A-113, 82A-114 and 82A-123, R.C.M. 1947, are repealed."

Separability Clause: Section 5 of Chapter 272, Laws 1971 read "If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

Effective Date: Section 1 of Chapter 272, Laws 1971 read "Chapters 1 and 21 of Section 1 of this act and Sections 4 and 5 of this act are effective upon its passage and approval. Chapters 2 through 20 of section 1 of this act are effective upon the date the governor signs an executive order implementing the chapter or on December 31, 1972, whichever occurs first. The governor shall file the executive order with the secretary of state on the day the order is signed. The secretary of state shall file and record the order and send a copy of the order to each addressee on his official mailing list for the Revised Codes of Montana and to each addressee on the mailing list for the Revised Codes of Montana and to each addressee on the mailing list of the publisher of the Revised Codes of Montana. Section 2 of this act is effective when Chapter 4 of Section 1 of this act is effective, and Section 3 is effective when Chapter 2 of Section 1 of this act is effective."

80-2704. Receipt of financial assistance authorized - co-operation with other agencies and organizations - grants to other agencies and organizations. The department may apply for and receive grants, allotments, or allocations of funds or other assistance for purposes pertaining to the problems of alcohol and drug dependence, or related social problems, under laws and rules of the United States, any other state, or any private organization. The department may co-operate with any other government agency or private organization in programs on alcohol and drug dependence related social problems. In carrying out co-operative programs, the department may make grants of financial assistance to government agencies and private organizations under terms and conditions agreed upon.

[History: Enacted Section 4, Chapter 303, L. 1969.]

80-2705. Department to administer act. The department shall administer the provisions of this act.

[History: Enacted Section 5, Chapter 303, L. 1969.]

80-2706. State and local government to co-operate with department - not subject to its control. All agencies of state government, local government, and all state and local government employees shall, upon request, co-operate with the department in its activities under this act, but nothing in the act shall be construed to give the department control over any state or local agency or employee, unless otherwise provided by law.

[History: Enacted Section 6, Chapter 303, L. 1969.]

80-2707. Deposit of funds from federal or private sources with state treasurer. Funds available to the department from federal or private sources for use in alcohol and drug dependence prevention, treatment, and control programs, shall be deposited with the state treasurer to the account of the department in the federal and private revenue fund.

[History: Enacted Section 7, Chapter 303, L. 1969.]

Separability Clause: Section 8 of Chapter 303, Laws 1969 read "It is the intent of the legislative assembly that if part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

80-2708. Declaration of policy. It is the policy of the state of Montana to recognize alcoholism as an illness and that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.

[History: Enacted 69-6211 by Section 1, Chapter 302, L. 1974; redesignated 80-2708 by Section 6, Chapter 280, L. 1975.]

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA: HB 627

Section 1. Section 2709, R.C.M. 1947, is amended to read as follows:

80-2709. Definitions. For purposes of this chapter:

(1) "alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private agency meeting the standards prescribed in section 80-2713(1) and approved under section 80-2713;



(3) "approved public treatment faeility" means a treatment agency operating under the direction and control of the department or providing treatment under this chapter through a contract with the department and approved under section 80-2713;

(4) "department" means the department of institutions provided for in section 82A-801, R.C.M. 1947;

(5) "incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment;

(6) "incompetent person" means a person who has been adjudged incompetent by the district court;

(7) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(8) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling, which may be extended to alcoholics, intoxicated persons, and family members;

(9) "family member", is the spouse, mother, father, child, or member of the household of an alcoholic whose life has been affected by the actions of the alcoholic and may require treatment;

(10) "prevention" has meaning on four levels; these are:

(a) education to provide information to the school children and general public relating to alcohol dependence and alcoholism, treatment, and rehabilitative services and to reduce the consequences of life experiences acquired by contact with an alcoholic;

(b) early detection and recovery from the illness before lasting emotional or physical damage, or both, have occurred;

(c) If lasting emotional or physical damage, or both, have occurred, to arrest the illness before full disability has been reached;

(d) the provision of facility requirements to meet division program standards and improve public accessibility for services."

Section 2. Section 80-2710 R.C.M. 1947, is amended to read as follows:

**80-2710. Powers of department.** The department may:

(1) plan, establish, and maintain treatment programs as necessary or desirable;

(2) coordinate its activities and cooperate with alcoholism programs

in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this and other states for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;

(3) do other acts and things necessary or convenient to execute authority expressly granted to it; and

(4) provide treatment facilities for alcoholics, intoxicated persons, and family members."

**80-2711. Duties of department.** The department shall:

(1) develop, encourage, and foster state-wide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in co-operation with public and private agencies, organizations, and individuals and provide technical assistance and consultation services for these purposes;

(2) co-ordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) co-operate with the department of institutions and board of pardons in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) co-operate with the department of education, the superintendent of public instruction, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearinghouse for information relating to alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the state's comprehensive health plan;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and co-operate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries of the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment

(14) co-operate with the department of justice in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness; and

(17) submit to the governor an annual report covering the activities of the department.

History: Enacted 69-6214 by Section 4, Chapter 302, L. 1974; redesignate 80-2711 by Section 6, Chapter 280, L. 1975.

Section 3. Section 80-2712, R.C.M. 1947, is amended to read as follows:

**80-2712. Comprehensive program for treatment.** (1) The department shall establish a comprehensive and coordinated program for the treatment of alcoholics, intoxicated persons, and family members.

(2) The program shall include:

(a) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(b) inpatient treatment;

(c) intermediate treatment; and

(d) outpatient and followup treatment.

(3) The department shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 80-2715 through 80-2718. Treatment may not be provided at a correctional institution except for inmates.

(4) All appropriate public and private resources shall be coordinated with and utilized in the program if possible.

(5) The department shall prepare, publish, and distribute annually a list of all approved public and private treatment facilities."

**80-2713. Facility standards -- inspections -- approvals.** (1) The department shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded to patients.

(2) The department periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

(3) The department shall maintain a list of approved public and private treatment facilities.

(4) Each approved public and private treatment facility shall file with the department on request, data, statistics, schedules, and information the department reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns thereof, shall be removed from the list of approved treatment facilities.

(5) The department, after holding a hearing in accordance with the Administrative Procedures Act, may suspend, revoke, limit, or restrict an approval, or refuse to grant an approval, for failure to meet its standards.

(6) A district court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

(7) Upon petition of the department and after a hearing held upon reasonable notice to the facility, a district court may issue a warrant to the department authorizing it to enter and inspect at reasonable times, and examine the books and accounts of, any approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this act.

[History: Enacted 69-6216 by Section 6, Chapter 302, L. 1974; redesignated 80-2713 by Section 6, Chapter 280, L. 1975.]

Section 4. Section 80-2714, R.C.M. 1947, is amended to read as follows:

**"80-2714. Acceptance for treatment -- rules.** The department shall adopt rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics, intoxicated persons, and family members.

In adopting the rules the department shall be guided by the following standards:

(1) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(2) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

(3) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

(4) An individualized treatment plan shall be prepared and maintained on a current basis for each person.

(5) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment."

**80-2715. Voluntary treatment of alcoholics.** (1) An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, a legal guardian, or other legal representative may make the application.

(2) Subject to rules adopted by the department, the administrator of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to departmental rules, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

(3) If a patient receiving in-patient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator of the treatment facility that the patient is an alcoholic who requires help, the department shall arrange for assistance in obtaining supportive services and residential facilities.

(4) If a patient leaves an approved public treatment facility, with or against the advice of the administrator of the facility, the department shall make reasonable provisions for his transportation to another facility or to his home. If he has no home he shall be assisted in obtaining shelter. If he is a minor or an incompetent person the request for discharge from an in-patient facility shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent if he was the original applicant.

[History: Enacted 69-6218 by Section 8, Chapter 302, L. 1974; redesignated 80-2715 by Section 6, Chapter 280, L. 1975.]

Section 5. Section 80-2716, R.C.M. 1947, is amended to read as follows:

"80-2716. Treatment and services for intoxicated persons and persons incapacitated by alcohol. (1) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility, or other health facility by the police.

(2) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police and forthwith brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available he shall be taken to an emergency medical service customarily used for incapacitated persons. The police, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. No entry or other record may be made to indicate that the person taken into custody under this section has been arrested or charged with a crime.

(3) A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

(4) A person who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility (1) once he is no longer incapacitated by alcohol, or (2) if he remains incapacitated by alcohol for more than forty-eight (48) hours after admission as a patient, unless he is committed under section 80-2717. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

(5) A person who is not admitted to an approved public treatment facility and is not referred to another health facility, may be taken to his home. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(6) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected."

Section 6. Section 80-2717, R.C.M. 1947, is amended to read as follows:

"80-2717. Emergency commitment. (1) An intoxicated person who (a) has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or (b) is incapacitated

by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgement as to the need for treatment.

(2) The certifying physician, spouse, guardian, or relative of the person to be committed, or any responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within two (2) days before the certificate's date and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the department is not eligible to be the certifying physician.

(3) Upon approval of the application by the administrator of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection (5).

(4) The administrator of an approved public treatment facility shall refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(5) When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than five (5) days. If a petition for involuntary commitment under section 80-2718 has been filed within the five (5) days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than ten (10) days after filing the petition.

(6) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within twenty-four (24) hours after commitment by the department, who shall provide a reasonable opportunity for the person to consult counsel."

**80-2718. Involuntary commitment of alcoholics.** (1) A person may be committed to the custody of the department of institutions by the district court upon the petition of his spouse or guardian, a relative, the certifying physician, or the chief of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he (a) has threatened, attempted, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (b) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgement as to the need for treatment. The petition shall be accompanied by a certifi-

icate of a licensed physician who has examined the person within two (2) days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the department is not eligible to be the certifying physician.

(2) Upon filing the petition, the court shall fix a date for a hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, a parent or his legal guardian if he is a minor, the administrator incharge of the approved public treatment facility to which he has been committed for emergency care, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

(3) At the hearing the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall have a right to have a licensed physician of his own choosing examine him and testify on his behalf, and if he has no funds with which to pay such physician, the reasonable costs of one such examination and testimony shall be paid by the county. The person shall be present unless the court believes that his presence is likely to be injurious to him; he shall be advised of his right to counsel and, if he is unable to hire his own counsel, the court shall appoint an attorney to represent him at the expense of the county. The court shall examine the person in open court, or if advisable, shall examine the person in chambers. If he refuses an examination by a licensed physician and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the department of institutions for a period of not more than five (5) days for purposes of a diagnostic examination.

(4) If after hearing all relevant evidence, including the results of any diagnostic examination by the department of institutions, the court finds that grounds for involuntary commitment have been established by clear and convincing evidence, it shall make an order of commitment to the department of institutions. It may not order commitment of a person unless it determines that the department of institutions is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

(5) A person committed under this section shall remain in the custody of the department of institutions for treatment for a period of thirty (30) days unless sooner discharged. At the end of the thirty (30) day period, he shall be discharged automatically unless the department of institutions before expiration of the period obtains a court order from the district court of the committing district for his recommitment upon the grounds set forth in subsection (1) for a further period of ninety (90) days unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the department of institutions shall apply



for recommitment if after examination it is determined that the likelihood still exists.

(6) A person recommitted under subsection (5) who has not been discharged by the department of institutions before the end of the ninety (90) day period shall be discharged at the expiration of that period unless the department of institutions, before expiration of the period, obtains a court order from the district court of the committing district on the grounds set forth in subsection (1) for recommitment for a further period not to exceed ninety (90) days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the department shall apply for recommitment if after examination it is determined that the likelihood still exists. Only two (2) commitment orders under subsections (5) and (6) are permitted.

(7) Upon the filing of a petition for recommitment under subsections (5) or (6), the court shall fix a date for hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, the original petitioner under subsection (1) if different from the petitioner for recommitment, one of his parents or his legal guardian if he is a minor, and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection (3).

(8) A person committed to the custody of the department of institutions for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(a) in case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that he is no longer in need of treatment or the likelihood no longer exists; or

(b) in case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition, or treatment is no longer adequate or appropriate.

(9) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of any proceedings relating to his commitment and recommitment, and have counsel appointed by the court or provided by the court, if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

(10) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the

patient for treatment, the department of institutions may transfer him to the private treatment facility.

(11) A person committed under this section may at any time seek to be discharged from commitment by writ of habeas corpus or other appropriate means.

(12) The venue of proceedings under this section is in place in which person to be committed resides or is present.

[History: Enacted 69-6221 by Section 11, Chapter 302, L. 1974; redesignated 80-2718 by Section 6, Chapter 280, L. 1975.]

**80-2719. Records of alcoholics and intoxicated persons.** (1) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(2) Notwithstanding subsection (1), the department may make available information from patient's records for purposes of research into the causes and treatment of alcoholism. Information under this subsection shall not be published in a way that discloses patient's names or other identifying information.

[History: Enacted 69-6222 by Section 12, Chapter 302, L. 1974; redesignated 80-2719 by Section 6, Chapter 280, L. 1975.]

**80-2720. Visitation and communication of patients.** (1) Subject to reasonable rules regarding hours of visitation which the department may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel, and for continuing contact with family and friends consistent with an effective treatment program.

(2) Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. The administrator may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

[History: Enacted 69-6223 by Section 13, Chapter 302, L. 1974; redesignated 80-2720 by Section 6, Chapter 280, L. 1975.]

**80-2721. Application of Administrative Procedure Act.** The Administrative Procedure Act applies to and governs all administrative actions taken under this act.

[History: Enacted 69-6224 by Section 14, Chapter 302, L. 1974; redesignated 80-2721 by Section 6, Chapter 280, L. 1975.]

**80-2722. Departmental reports to legislature.** The department shall achieve full implementation of the provisions of the act, as set forth in this chapter and related sections, no later than January 1, 1976. A progress report on the implementation shall be made to the 1975 legislative session. Thereafter the department shall report, to each legislative session, on the status of the implemented act. This report, or any part thereof, may be included as the department's state plan for alcohol abuse and alcoholism.

History: Enacted 69-6224 by Section 19, Chapter 302, L. 1974; amended and redesignated 80-2722 by Section 3, Chapter 280, L. 1975.

Amendments: The 1975 amendment renumbered this section; deleted "and the department of institutions" after "The department" at the beginning of the section; and substituted "department" for "departments" at the beginning of the third sentence.

Repealing Clause: Section 20 of Chapter 302, Laws 1974 read "Sections 4-164 and 69-6202, R.C.M. 1947, are repealed."

**80-2723. Criminal laws limitations.** (1) No county, municipality, or other political subdivision may adopt or enforce a local law, ordinance, resolution, or rule having the force of law that includes drinking, being a common drunkard, or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or sanction.

(2) Nothing in this section affects any law, ordinance, resolution, or rule against drunken driving, driving under the influence of alcohol, or other similar offense involving the operation of a vehicle, aircraft, boat, machinery, or other equipment, or regarding the sale, purchase, dispensing, possessing, or use of alcoholic beverages at stated times and places or by a particular class of persons.

[History: Enacted 80-2723 by Section 2, Chapter 403, L. 1975.]

**80-2724. Public intoxication not criminal offense.** (1) A person who appears to be intoxicated or incapacitated by alcohol in public commits no criminal offense solely by reason of being in such condition, but may be detained by a peace officer for the person's own protection. A peace officer who detains a person who appears to be intoxicated or incapacitated by alcohol in public shall proceed in the manner as provided by section 80-2716.

(2) If none of the alternatives in section 80-2716 is reasonably available, a peace officer may detain a person who appears to be intoxicated or incapacitated by alcohol in jail until the person is no longer creating a risk to himself or others.

(3) A peace officer, acting within the scope of his authority under this chapter, shall not be personally liable for his actions.

[History: Enacted 80-2724 by Section 3, Chapter 403, L. 1975.]

Repealing Clause: Section 4 of Chapter 403, Laws of 1975 read "Section 94-8-105 is repealed."

Section 7. There is a new R.C.M. section numbered 80-2725 that reads as follows:

**80-2725. State-approved alcoholism programs utilizing funding generated by taxation on alcoholic beverages.** (1) Revenue generated by 4-1-401 and 4-1-404 for the treatment, rehabilitation, and prevention of alcoholism may be distributed

in either of the following manners:

(a) as payment of fees for alcoholism services provided by state-approved alcoholism programs, certified alcoholism counselors, licensed physicians, and licensed hospitals; and

(b) as grants to persons operating state-approved alcoholism programs.

(2) No person operating a state-approved alcoholism program may be required to provide matching funds as a condition of receiving a grant under subsection (1) of this section.

(3) In addition to funding received under this section, a person operating a state-approved alcoholism program may accept gifts, bequests, or the donation of services or money for the treatment, rehabilitation, or prevention of alcoholism.

(4) No person receiving funding under this section to support operation of a state-approved alcoholism program may refuse alcoholism treatment, rehabilitation, or prevention services to a person solely because of that person's inability to pay for those services.

(5) A grant made under this section is subject to the following conditions:

(a) The grant application must contain an estimate of all program income including income from earned fees, gifts, bequests, donations, and grants from other than state sources during the period for which grant support is sought.

(b) Whenever, during the period of grant support, program income exceeds the amount estimated in the grant application, the amount of the excess shall be reported to the grantor.

(c) The excess shall be used by the grantee under the terms of the grant in accordance with one or a combination of the following options:

(i) use for any purpose that furthers the objectives of the legislation under which the grant was made; or

(ii) deduct from total project costs to determine the net costs on which the grantor's share of the costs is based.

(6) Revenue generated by 4-1-401 and 4-1-404 for the treatment, rehabilitation, and prevention of alcoholism which has not been encumbered for those purposes by counties of Montana or the division shall be returned to the state's general fund within 30 days after the close of each fiscal year.

Section 8. Section 4-1-401 R.C.M. 1947, is amended to read as follows:

**"4-1-401. Licence tax on liquor -- amount -- distribution of proceeds.** The department of revenue is hereby authorized and directed to charge, receive and collect at the time of sale and delivery of any liquor under any provisions of the laws of the state of Montana a license tax of 10% of the retail selling

price on all liquor so sold and delivered. Said tax shall be charged and collected on all liquor brought into the state and taxed by the department of revenue. The retail selling price shall be computed by adding to the cost of said liquor the state markup as designated by the department. Said 10% license tax shall be figured in the same manner as the state excise tax and shall be in addition to said state excise tax. The department of revenue shall retain the amount of such 10% license tax so received in a separate account. Two-thirds of these revenues shall be distributed to the counties according to the amount of liquor purchased in each county. One-third of these revenues shall be retained by the state. Provided, however, in the case of purchases of liquor by a retail liquor license for use in his business, the department shall make such regulations as are necessary to apportion that proportion of license tax so generated to the county where the licensed establishment is located, for use as provided in section 4-1-402, R.C.M. 1947. The department of revenue shall pay quarterly to each county treasurer the proportion of the license tax due each county.

The county treasurer of each county shall retain 50% of said license tax, and shall, within 30 days after receipt thereof, apportion the remaining 50% thereof to the treasurers of the incorporated cities and towns within his county, said apportionment to be based in each instance upon the proportion which the gross sale of liquor in such incorporated city or town bears to the gross sale of liquor in all of the incorporated cities and towns in his said county.

Of the 50% of the tax retained by the county, the county treasurer shall deposit six-sevenths of this amount in a fund within the county for the treatment, rehabilitation, and prevention of alcoholism as approved by the state of Montana. The remaining one-seventh of the funds shall be retained in the county treasury for use by that county.

The one-third of the license tax on liquor retained by the state shall be deposited with the state treasurer to the credit of the department of institutions each quarter for the treatment, rehabilitation and prevention of alcoholism as approved by the state."

Section 9. Section 4-1-404, R.C.M. 1947, is amended to read as follows:

"4-1-404. Tax on imported beer -- computation in case of barrels of capacity other than thirty-one gallons. A tax of three dollars (\$3) per barrel of thirty-one (31) gallons, is hereby levied and imposed on each and every barrel of beer manufactured out of this state and sold herein by any wholesaler, which said tax shall be due at the end of each month from said wholesaler, upon any such beer so sold by him during that month. As to any beer imported and sold in containers other than barrels, or in barrels of more or less capacity than thirty-one (31) gallons, the quantity content shall be ascertained and computed by the department of revenue in determining the amount of tax due, as herein provided for. An additional tax of \$1.00 per barrel is levied and imposed as provided by this section, and such additional tax is also to be levied and imposed at the same rate upon beer manufactured within the state. The additional tax of \$1.00 is to be deposited, notwithstanding sections 4-1-407 and 4-1-408,

or any other provision, with the state treasurer to the credit of the department of institutions each quarter for the treatment, rehabilitation, and prevention of alcoholism as approved by the state."

# ALCOHOL SERVICES

## CHAPTER 3

### ADAPTIVE SERVICES DIVISION

#### Sub-Chapter 1

#### Section 20-2.3(1)-S300 State Plan

#### 20-2.3(1)-S310 Alcohol Treatment Programs

#### Sub-Chapter 1

#### State Plan, Standards

20-2.3(1)-S300 STATE PLAN (1) The plan is for state participation under P. L. 91-6-6 (Hughes Bill) and is necessary for application for a grant under this law. The department has been designated as the sole agency for supervision of the administration of the plan. The plan sets forth a survey of the need for the prevention and treatment of alcohol abuse and alcoholism, the facilities needed to provide services, and it serves as a guide for the development and distribution of facilities and programs throughout the state.

(2) The state plan of the Addictive Diseases Bureau is adopted as a rule. The state plan is voluminous, and its inclusion in full in this rule would be cumbersome. It is deemed not expedient to include the entire context of the plan, and a summary of the plan is therefore given in section (1) of this rule. Copy of the plan is available for inspection, or copies thereof may be obtained at the expense of the person requesting the same at prices fixed to cover the cost of duplication and mailing. Inquiries should be made of the director of the department for inspection of the plan or requesting a copy of the plan. (History: Sec. 80-2702, R.C.M. 1947; transferred from Title 16 by the 1975 Legislature; TRANS: Order MAC No. 20-2-3; Adp. 1/1/76; Eff. 1/2/77.)

20-2.3(1)-S310 ALCOHOL TREATMENT PROGRAMS (1) Purpose. The purpose of this rule is to establish treatment standards for the approval of programs extending treatment services to alcoholics, intoxicated persons and persons incapacitated by alcohol pursuant to Sec. 80-2713, R.C.M. 1947, standards for acceptance of persons into the treatment program and standards by which the administrator may determine which persons may be admitted to an approved public treatment program as an alcoholic pursuant to Sec. 80-2714, R.C.M. 1947. Prior to approval and prior to being designated as part of the state program for treatment, each facility shall be licensed in accordance with Sec. 69-5203, R.C.M. 1947.

(2) Definitions. In addition to the terms defined in Section 80-2709, R.C.M. 1947,

"Administrator" means the person in charge, care or control of the treatment program and responsible for the operation of the program.

"Care" means services provided by training personnel, such as nurses, aides, alcoholism helpers or counsellors.

"Department" means the department of institutions.

"Emergency treatment program" (non-hospital) means a program which is advertised, announced or maintained for the expressed or implied purpose of providing individuals admitted there with short term residence, nursing, convalescent or rehabilitative care, supervision and care incidental to withdrawal from alcohol.

"Intermediate treatment program" means a community-based residential program providing therapeutic services including supervision and an opportunity for re-learning social skills to assist clients to return to the community. Services are provided for the individual who needs less direct supervision than emergency treatment and more services than available through an outpatient program.

"Inpatient treatment program" means a program providing a residential setting for clients who require continuous care and treatment with specific therapeutic functions beyond those offered by emergency, intermediate, or outpatient programs.

"Outpatient treatment program" means a program providing counselling and outreach services for individuals who are able to function without the structure of emergency, intermediate or inpatient treatment programs.

"Physician" means a physician licensed by the State of Montana.

"Outpatient", when used to modify a person, facility or service, means a person who is not a resident of a treatment program.

"Patient" means a person who is formally diagnosed as in need of and admitted to a treatment program.

"Person" means an individual or group of individuals, association, partnership or corporation.

"Resident" means any person assigned, living or residing in a dwelling or rooming unit of a treatment program.

"Treatment facility" means any public or private place, establishment, building, rooming house, boarding house, lodging house, dwelling, home, farm, camp or other facility by whatever name known used to provide treatment services as an emergency and receiving facility, halfway and rehabilitation facility or comprehensive treatment center providing any or all of the following services to alcoholics, intoxicated persons, or persons incapacitated by alcohol: emergency, inpatient, intermediate or outpatient treatment. Non-medical facilities or eight (8) beds or less are not subject to facility licensure rules.



(3) Requirements for approval of alcohol treatment programs. Each public or private program providing services for alcohol treatment shall be subject to approval by the department. A certificate of approval shall be obtained annually. The certificate issued shall be conditional to establishing and operating programs in compliance with this rule.

(a) If a treatment program is determined to be in compliance with state requirements and applicable federal requirements, the department shall issue the certificate of approval to the program. This certificate shall be displayed in a conspicuous place of the program for which it is issued.

(b) Each certificate of approval shall be valid only in the possession of the person to which it is issued and shall not be subject to sale, assignment or other transfer, voluntary or involuntary, nor shall a certificate be valid for any location other than that for which it is issued.

(c) Each certificate of approval shall be for a period of one year from the date of issue unless revoked or suspended.

(d) Each certificate of approval shall be renewed annually. Each application for renewal shall be submitted on the form provided by the department not less than thirty (30) days prior to expiration.

(e) Programs in existence as of January 1, 1975 will be fully approved but must meet the standards of these rules by December 15, 1976. A contract/agreement shall be written between the department and the program in question stipulating specified objectives to be met within a definite time period for continuing approval. An orderly progression shall be set forth with time limits for the program to meet acceptable standards.

(f) Additional data, statistics, schedules and/or information shall be filed by the applicant as may be reasonably required by the department for the purpose of determining the applicant's conformance with this rule.

(4) Acceptance of persons into the treatment program.

(a) Voluntary treatment shall be encouraged and maintained when possible.

(b) Programs shall admit and care for only those persons for whom they can provide care and services appropriate to a person's physical, emotional and social needs.

(c) If an alcoholic is not admitted to an approved public treatment program for the reason that adequate and appropriate treatment is not available at that program or facility, the administrator shall refer the person to another public treatment program at which adequate and appropriate treatment is available.

(d) Any restrictions, priorities or special admission criteria used during initial screening shall be applied equally to all potential admissions regardless of source or referral, source of payment, race, creed, ethnic origin or sex.

(e) A person who, by evaluation, is found to require outpatient or intermediate treatment shall be initially assigned to a program providing such treatment or transferred to a program providing the appropriate treatment. If a person is found to require inpatient treatment, such treatment shall be made available to him.

(f) A program shall not prohibit a person from subsequent participation where the person has withdrawn from prior treatment or has relapsed after earlier treatment.

(g) An individualized treatment plan specifically tailored to meet the needs of the individual patient/client shall be prepared and maintained on a current basis for each patient/client.

(h) The staff of a program shall develop an appropriate referral plan for the resident deemed necessary to effect total and complete recovery and rehabilitation. Staff shall actively assist residents to make contact with clinics, Alcoholics Anonymous, social and welfare agencies, and other approved treatment programs suitable for follow-up care upon discharge from the program.

(5) Administrative management--governing body.

(a) A program shall have a governing body which is legally responsible for the conduct of the program.

(b) The governing body shall establish a philosophy of policies and goals.

(c) Policies shall be in writing governing admissions, discharges, length of stay, diagnostic groups to be served, scope of services, treatment regimens, staffing patterns, recommendations for continued treatment by referral or otherwise, and provision for a continuing evaluation of the program.

(d) The governing body shall be responsible for providing personnel, facilities, and equipment needed to carry out the goals and objectives of the program and meet the needs of the residents.

(e) The governing body shall appoint an administrator. Policies shall be in writing governing the qualifications and responsibilities of the administrator.

(6) Operational requirements for resident programs

(a) Food service.

(i) Food shall be provided and shall be wholesome and nutritionally balanced. Three meals or equivalent shall be served daily at regular times. Snacks shall be available to residents at all times.

(ii) Food not prepared on site shall be obtained from approved sources and shall be transported and served in an approved manner.

(b) Personal hygiene.

(i) Clean clothing, drinking cups, towels, soap, toothbrushes, combs, toothpaste or toothpowder, shaving equipment and other personal articles as required shall be available to each resident for his individual use.

(a) Residents' records: Residents' records shall be handled and stored in such a manner as to properly safeguard the confidentiality of their contents. Each resident's records shall include at least the following:

- (i) Identifying information including either name or identifying number, age, sex, and marital status.
- (ii) Social history.
- (iii) Dates of admission and discharge.
- (iv) Records of medical care, including physical examinations and medications taken.
- (v) Records of illnesses.
- (vi) At least semi-monthly written progress reports on each resident as applicable by program staff, plus a termination report.
- (vii) An individualized treatment plan containing both short term and long term goals.

(b) Other records and reports. The following other records and reports shall be made available for review by the department:

- (i) Resident admission register.
- (ii) Articles, by-laws, rules and regulations, minutes of meetings of the governing body, and operational policies established by the governing body of the treatment program.
- (iii) Written job descriptions for personnel.
- (iv) Formal written agreements for contracted services.
- (v) Record of menus served during the previous 30-day period.
- (vi) Records or reports reasonably required by the department.

(c) Confidentiality: Patient record information may be maintained or disseminated, by compulsory process or otherwise, outside the patient's treatment program which collected such information, only as provided in accordance with section 333 of P.L. 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (84 Stat. 1953, 42 U.S.C. 4582), as amended by section 122 (a) of P.L. 93-282, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974.

(3) Requirements specific to emergency treatment provided by a program affiliated with or part of the medical service of a general hospital.

(a) An emergency treatment program may be provided in a non-hospital or hospital-based setting. That program shall provide residents with short term supervised care incidental to alcoholism or alcohol abuse. An emergency program shall be in a place where an alcoholic, intoxicated person or person incapacitated by alcohol can be:

- (i) Sobered up in a safe environment and protected from the dangers of his drunken behavior to himself and others.

(a) Residents' records: Residents' records shall be handled and stored in such a manner as to properly safeguard the confidentiality of their contents. Each resident's records shall include at least the following:

- (i) Identifying information including either name or identifying number, age, sex, and marital status.
- (ii) Social history.
- (iii) Dates of admission and discharge.
- (iv) Records of medical care, including physical examinations and medications taken.
- (v) Records of illnesses.
- (vi) At least semi-monthly written progress reports on each resident as applicable by program staff, plus a termination report.

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(3) Requirements specific to emergency treatment provided by a program affiliated with or part of the medical service of a general hospital.

(a) An emergency treatment program may be provided in a non-hospital or hospital-based setting. That program shall provide residents with short term supervised care incidental to alcoholism or alcohol abuse. An emergency program shall be in a place where an alcoholic, intoxicated person or person incapacitated by alcohol can be:

- (i) Sobered up in a safe environment and protected from the dangers of his drunken behavior to himself and others.

(11) Requirements specific to outpatient treatment programs.

(a) An outpatient program shall provide alcoholism counselling services to those in need and shall include an active outreach philosophy for early identification of individuals showing signs of reduced social-vocational functioning due to excessive drinking.

(b) Program. An outpatient treatment program shall be available on a 24-hour a day, 7-day a week basis. A revolving schedule of counsellors may be used to insure a staff member on call at any time. The program shall have a written plan for acceptance to the program, resources available (program or community), referral procedures for more intensive services if needed.

(i) Services shall include appropriate counselling and referral.

(ii) An individualized treatment plan shall be written and maintained on a current basis for each client and shall include follow-up plans.

(c) Staff.

(i) Counselling staff shall be trained in the field of alcoholism counselling and education and shall demonstrate an ability to work with clients and a knowledge of the etiology of alcoholism.

(ii) Sufficient staff shall be available to provide 24-hour services on call.

(iii) Staff shall be familiar with community resources for referral, if needed (e.g., medical, social, vocational, mental health, A.A., etc.).

(iv) Continuing education in counselling skills shall be made available for staff. (History: Secs. 80-2713, 80-2714, R.C.M. 1947; transferred from Title 16 by the 1975 Legislature; TRANS: Order MAC No. 20-2-3; Adp. 1/1/76; Eff. 1/2/77.)

## (c) Staff.

(i) The minimum staff shall be determined by the governing body.

(ii) A staff member who is qualified to supervise the residents and the center shall be on duty at all times. In addition, the administrator shall be on call and available for emergencies.

(iii) There shall be an adequate number of qualified staff members in the specialties required by the treatment regimen or regimens of an inpatient treatment program such as alcoholism counsellors, psychologists, social workers, psychiatrists, clergymen, etc. Their qualifications shall conform to the prevailing standards of these specialties with specific training and/or experience in the treatment of alcoholism. This does not preclude the use of residents for work assignments when it is part of the individual's written treatment plan.

(10) Requirements specific to intermediate treatment programs (e.g., halfway house).

(a) Program. Supervision and services shall be available on a 24-hour, 7-day a week basis. The program shall have a written plan for the admission, care, treatment and discharge of all clients. The following services and programs shall be provided:

(i) Counselling staff shall be available to provide evaluation, counselling and referral.

(ii) Recreational and rehabilitation activities shall be planned for therapeutic purposes and shall be under guidance of program staff. All residents shall be encouraged to participate in appropriate activities, both in the residential program and in the community. The program shall place priority on those activities which will help residents resume normal social life in the community.

(b) A resident shall be required to pay for services rendered within the treatment plan, consistent with his ability to pay or capacity to maintain employment.

(c) In order to maintain residency and be qualified for funding for services, a resident must be formally admitted, there must be a treatment plan and client must participate in the program.

(d) An individualized treatment plan shall be prepared and maintained on a current basis for each client.

(e) Staff.

(i) A house manager (staffed to provide 24 hour coverage of service). The house manager need not be on duty if the administrator or counsellor is available. The house manager position may include salaried resident employees.

(ii) A minimum of one staff member shall be on duty for admitting, treating and discharging purposes. Adequate staff shall be provided to guarantee care as defined in this section.

(ii) Protected from developing the sometimes life-threatening mental and physical symptoms that ensue when a habitual excessive drinker abruptly terminates his drinking.

(iii) Screened for the presence of the diversity of medical and surgical conditions that are often the consequences of drunkenness, alcoholism or both, and be referred expeditiously to a hospital for definitive diagnosis and treatment.

(iv) Provided with encouragement, advice, counselling and referral to other treatment and service facilities and agencies for help in controlling his alcohol problem if he has one.

(b) Program. An emergency treatment program shall be available on a 24-hour day, 7-day week basis. The program shall have a written plan for the admission, care, treatment and discharge of all clients.

(i) A record shall be made of the resident's clothing and valuables and signed by the resident or sponsor and a staff member of the program.

(ii) Counselling staff shall be available to provide appropriate evaluation, counselling and referral.

(iii) An individualized treatment plan shall be prepared and maintained on a current basis for each client.

(iv) A minimum of one staff member shall be on duty for admitting, treatment and discharging purposes. Adequate staff shall be provided to guarantee care as defined in this section.

(9) Requirements specific to inpatient treatment programs.

(a) An inpatient treatment program is defined as a setting for clients who require continuous care and treatment with specific therapeutic functions beyond those offered by emergency or short term programs.

(b) Program. Inpatient treatment services shall be provided on a 24-hour, 7-day a week basis. The program shall have a written plan for the admission, care, treatment and discharge of all clients. The following services and programs shall be provided.

(i) Personnel, facilities and equipment sufficient to carry out a program which will assist the client to regain physical, mental, social and vocational abilities to function in society on a productive basis.

(ii) An individualized treatment plan shall be written to include: evaluation and diagnosis (medical and psychological if required); intensive counselling (individual and group); alcoholism education; referral to specialized resources in the community upon release (or prior to release if appropriate); and a written post-discharge plan focusing on a continuum of alcoholism services. There shall be a referral to a community-based resource such as a local alcoholism program of Alcoholics Anonymous.

## (c) Medical.

(i) Medical services shall be available under the supervision of a physician, and any resident at his own expense shall have the right to consult with the physician or dentist of his choice.

(ii) Written medical policies and procedures shall be readily available to staff. Written medical policies and procedures as to the course of action to be followed in the care of occupants having minor acute illnesses and in the event of medical emergencies including dangerous behavior shall be developed with the assistance and written approval of a physician or a representative of the medical board.

(iii) Arrangements for access to medical and surgical care shall be made with a general hospital for residents when it is needed. The program is not required to assume responsibility for the cost of such care.

(iv) Personal observation and inquiry shall be made of each person upon admission as to chronic illness or physical disability or vermin infestation or possible contagious disease that may require medical attention. Such medical attention shall be immediately made available when necessary and no person shall be admitted who is in need of medical services for a severe physical or emotional illness including severe alcohol intoxication or its withdrawal symptoms except in a program capable of providing the necessary services. The program is not responsible for the cost of such care.

(v) First aid equipment and supplies shall be provided and shall be available for emergency and routine use conforming to written procedures.

(vi) Arrangements for access to dental care shall be made available for the relief of pain control of infection. The program is not required to assume responsibility for the cost of such care.

(vii) Mental health consultation shall be made available for emergencies. The program is not required to assume responsibility for the cost of such services.

(viii) Medications shall be handled in accordance with provisions of applicable state and federal laws and regulations.

(ix) Medications purchased independently by a resident or supplied by his physician or medicines used by the resident shall be stored in such a manner that the use of such materials can be restricted to self administration by the resident.

(x) Methods for cleaning, handling and storing of all medical supplies and equipment shall be such as to prevent the transmission of infection through their use.

## (d) Responsibility.

(i) Policies and procedures shall be established by each program to insure proper environmental and personal health conditions for protection of the health of the residents.

(7) Records and Reports.



(11) Requirements specific to outpatient treatment programs.

(a) An outpatient program shall provide alcoholism counselling services to those in need and shall include an active outreach philosophy for early identification of individuals showing signs of reduced social-vocational functioning due to excessive drinking.

(b) Program. An outpatient treatment program shall be available on a 24-hour a day, 7-day a week basis. A revolving schedule of counsellors may be used to insure a staff member on call at any time. The program shall have a written plan for acceptance to the program, resources available (program or community), referral procedures for more intensive services if needed.

(i) Services shall include appropriate counselling and referral.

(ii) An individualized treatment plan shall be written and maintained on a current basis for each client and shall include follow-up plans.

(c) Staff.

(i) Counselling staff shall be trained in the field of alcoholism counselling and education and shall demonstrate an ability to work with clients and a knowledge of the etiology of alcoholism.

(ii) Sufficient staff shall be available to provide 24-hour services on call.

(iii) Staff shall be familiar with community resources for referral, if needed (e.g., medical, social, vocational, mental health, A.A., etc.).

(iv) Continuing education in counselling skills shall be made available for staff. (History: Secs. 80-2713, 80-2714, R.C.M. 1947; transferred from Title 16 by the 1975 Legislature; TRANS: Order MAC No. 20-2-3; Adp. 1/1/76; Eff. 1/2/77.)



### SECTION 3

ADVISORY COUNCIL MEMBERS

ADVISORY COUNCIL BY LAWS

ADVISORY COUNCIL AGENDAS AND MINUTES OF MEETINGS



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The Advisory Council membership has been established so that  
both minority and poverty interests are represented.

BY-LAWS OF THE  
MONTANA ADVISORY COUNCIL ON ALCOHOL AND DRUG DEPENDENCY

ARTICLE I

NAME

The name of the Council is the Montana Advisory Council on Alcohol and Drug Dependency.

ARTICLE II

PURPOSE

The purpose of the Council shall be to comply with Public Laws which require an advisory council for receipt of State and Federal alcohol and drug grant monies. The Council will advise the Department of Institutions.

ARTICLE III

MEMBERSHIP

SECTION I. MEMBERS. The Advisory Council shall consist of eight (8) members appointed by the Director with approval of the Governor. Persons selected for membership on the Advisory Council shall be chosen to allow for broad representation of population groups to be served, of governmental and employee groups, local citizens' groups, and representatives of major socio-economic and ethnic groups.

SECTION II. TENURE. Members shall serve at the pleasure of the Governor. Three consecutive absences from regular meetings shall require automatic recommendation, to the Director, for removal of that member from the Advisory Council. The member shall be notified in writing of the recommendation.

SECTION III. REIMBURSEMENT. Each member is entitled to be reimbursed for expenses at the same rate as provided for State employees.

Sections 59-538, 59-539, 59-801 R.C.M., 1947.

SECTION IV. HONORARIUM. All members who are not full time salaried officers or employees of Montana or any political subdivision of this State are entitled to be paid twenty-five dollars (\$25) for each day actually and necessarily engaged in the performance of Council duties.

#### ARTICLE IV

##### MEETINGS

SECTION I. MEETINGS. Meetings shall be held at least quarterly, and at other times upon the call of one or more of the following: Director of the Department of Institutions, Chairman of the Advisory Council, or a majority of the Council members. Meetings must be held in Helena unless prior authorization is given.

SECTION II. NOTICE. Notice of all meetings shall be sent by mail to the entire membership by the Director at least two weeks in advance of the meeting.

SECTION III. QUORUM. A majority of the membership constitutes a quorum to do business. In any case wherein a member of the Council attending a Council business meeting and must leave during the course of the meeting, he may delegate a proxy vote, in writing, to another member for that meeting only during his absence, otherwise, no proxy vote will be allowed.

SECTION IV. CONDUCT OF MEETINGS. The Chairman shall preside at all meetings and the meetings shall be conducted in accordance with the current Roberts' Rules of Order.

## ARTICLE V

### OFFICERS

SECTION I. OFFICERS. The Council shall, at its first meeting each fiscal year, elect a chairman and vice chairman. Officers must be elected by a majority vote. Term of office shall be one year. Officers may hold successive terms.

SECTION II. QUALIFICATIONS. All members are eligible to be elected to office.

SECTION III. VACANCY. A vacancy in an office shall be filled by a majority vote of the membership for the remainder of the term of office.

## ARTICLE VI

### DUTIES

The duties of the Council are:

- a) Review and make specific recommendations to be considered in the Montana State Comprehensive Plan for the prevention, treatment and control of alcohol abuse, alcoholism, drug abuse, and drug addiction.
- b) Generally advise the Department in the conduct of its comprehensive planning and evaluation activities and in setting of priorities.
- c) Review and make recommendations on all receipts and expenditures of all grant monies.

## ARTICLE VII

### AMENDMENTS

Changes and amendments to the by-laws of the Council may be made at any regular meeting by a vote of the majority of the total membership of



the Council provided that written notice of a proposed change is given at least two (2) weeks in advance of a meeting.

Reference:       Section 82A-110, R.C.M. 1947.  
                  PL 616, Sec. 303(3), (84 Stat. 1850)  
                  PL 92-255, Sec. 409(c)(2), (e)(3) (86 Stat. 82)

Agendas and minutes of all Advisory Council meetings are mailed to:

1. Alcohol and Drug Advisory Council members.
2. All alcohol and drug programs in Montana.
3. Alcohol Programs of Montana, Inc.
4. Region VIII, Denver
5. All state agencies and residents requesting to be included on our mailing list.

MINUTES  
OF  
ALCOHOL & DRUG ADVISORY COUNCIL

The Advisory Council met in the Department of Institutions Conference Room, Helena, Montana, on Friday, November 19, 1976.

Members Present:

Robert L. Van Horne, Ph.D. --- Chairman  
Rep. Martha Herlevi -- Vice-chairman  
Senator Larry Fasbender  
Gary Hall  
Peggy Skelton  
Sharon Pettit

Members Absent:

Katherine Hanrahan

Guests:

Audrey Atkinson, North Central Mental Health Center  
Jeff Hill, Crow Reservation  
Ben Jefferson, Crow Reservation  
Regional Addictive Diseases Resource Specialists -- Ron Hjelmstad  
Don MacDonald  
Howard Simmons/Lan Bauer  
Jim Scott  
Ken Anderson  
  
Boyd Andrews, Boyd's Guest House  
Members North American Indian Alliance, Butte

Staff:

Mike Murray, Chief, Addictive Diseases Bureau  
George Swartz, Drug Coordinator  
Terry Stanclift, Training and Certification Supervisor

The meeting was called to order at 7:00 p.m. by Dr. Van Horne. Minutes of the last Advisory Council meeting were approved.

Mike Murray handed out copies of the new organization and function charts and explained them in detail. He said that the organization chart has been approved by the Department of Institutions and will go to the Personnel Department on November 22, 1976. He also announced the resignation of Fred Barta effective November 26, 1976.

Mike Murray reported on the current status of regionalization of drug and alcohol programs in Montana, approved by the Advisory Council at Fairmont on January 28, 1976. Five Regional Addictive Diseases Resource Development Specialists were hired. The existing mental health boards were contacted to see if they would be willing to expand their mental health concept to include alcohol and drugs. Four Boards agreed to do this; one Board elected to develop a sub-corporation; another board operates as a mental health board in the morning and in the afternoon deals with alcohol and drugs with additional members present; another has a subcommittee to handle drugs and alcohol. As of September, the Region III Board had not had a separate alcohol or drug issue on its agenda. However, after meeting with Mike Murray and Dr. Carlson, the Board Chairman and Mental Health Center Director agreed that they would start dealing with these problems. Ms. Atkinson questioned whether the RADRDS were both drug and alcohol. Mr. Murray replied that this is in the state plan and that the drug plan will be regionalized by next March.

The five RADRDS gave their progress reports on their regions:

Region I -- Ron Hjeltnstad: Contract is with the Region I Mental Health Board. They have agreed to function as a Human Resource Board to administer the alcohol and drug program. The Board is composed of county commissioners or their designees from the 17 counties. The Regional Plan is 90 percent complete and should be complete by December 15.

Region II -- Don MacDonald: The Board of Directors consists of the nine county commissioners. It is the same as the Mental Health Board with the exception of Chouteau County which does not participate in mental health. During December hearings will be held on the regional state plan for assessment and needs in Region II from subacute detox to a need for outreach coordinators for various service providers.

Region III -- Howard Simmons: With the resignation of Harold Selvig, Dr. Simmons announced that he and Dr. Lan Bauer would work together as the regional coordinators for Region III. The Board consists of county commissioners or their designees from all 11 counties except Golden Valley. Dr. Simmons said that a recent evaluation revealed a serious underfunding to the Indian programs. He is trying to develop alternate sources of funding such as third party payments, encourage private fees, and fees for assisting the legal system. Region III does not have a regional plan at this time.

Region IV -- Jim Scott: Mr. Scott explained that he is employed as the director of the Alcoholism Rehabilitation Association by the Mental Health Board and as the Regional Coordinator for Region IV. The Board consists of county commissioners from 8 of the 12 counties. They meet as separate units, first as mental health and then as alcohol and drug board. Mr. Scott said that ARA had undergone state evaluation and has had to update some policies and procedures and are getting their files up-to-date. He plans to hire more trained staff people. Powell County needs an alcohol counselor. The regional plan will include funding for 3 transitional living houses -- in Butte, Bozeman, and Helena.

Region V --- Ken Anderson: Region V chose to incorporate to further identity as alcohol and drug entity and to enable the writing of NIAAA grants. NIAAA grant will be written to stabilize existing programs and develop a treatment center in Missoula and transitional living house in Kalispell and Missoula. The incentive grant will be integrated with the \$15,000 in the regional contract to place coverage in counties not currently covered. The Region V Advisory Council has a representative from each county and meets once a month.

Senator Fasbender asked the RADRDs if they were attempting to obtain local funds. Each RADRD gave a brief explanation on local monies their programs are receiving. Mr. Hjelmstad said that the 1/3 cash match is getting to be too much to ask from these counties. A discussion on the use of the liquor tax followed.

Two films, "Guidelines" and "Alcohol, Drugs, or Alternatives," were shown.

The meeting was adjourned until 9:00 a.m. November 20, 1976.

The Advisory Council Meeting was called to order at 9:00 a.m. on November 20, 1976, by Dr. Van Horne.

Mr. George Swartz announced that there is \$53,000 drug mini-grant and contract money available to local communities. Thirty-six thousand dollars (\$36,000) is in grant money, and the rest is contract money. Eleven thousand dollars (\$11,000) has been committed by the Department for the Touche-Ross Evaluation System. Mr. Swartz proposed that \$30,000 be allocated \$6,000 each to the five human resource regions, leaving \$6,000 for a contingency fund for the Bureau. This proposal was approved unanimously by the Council.

Mr. Swartz requested approval for a \$6,000 contract for the Gallatin Council on Health and Drugs to develop a program on "Families Are Responsible." He stated that in the contract Gallatin Council would agree to help other communities establish this program. Lt. Hall moved that this program be funded for \$6,000. Senator Fasbender seconded the motion, and it was approved.

Mr. Swartz stated that he had \$10,000 left at the end of last fiscal year which would revert back to the federal government. In order not to lose this money, Mr. Swartz proposed that the Department contract with SMDP to develop a program outside of their region working with the Mental Health Center of Great Falls. He introduced Ms. Audrey Atkinson and asked her to explain the program.

Ms. Atkinson said that a task force was formed in Great Falls regarding solvent sniffing. They found a high degree of abuse in this area among the young people. The Mental Health Center is proposing a demonstration project using a control and experimental group of 24 youths, including 12 whites and 12 Indians. After 6 months, the Center will do a paper on its findings and submit it to the state. Lt. Hall made a motion that this program be funded for \$10,000. Senator Fasbender seconded the motion, and it was approved.

The proposal submitted from Perry Driscoll 2, 1 Home in the spring was reviewed and discussed. The Council recommended that funds be used for existing programs instead of starting new programs. If the \$40,000 becomes available, the Council recommended to fund existing programs as follows: \$8,000 to the Alcohol Service Center of Lincoln County; \$10,000 to Alcoholism Rehabilitation Association; \$2,000 to Rimrock Foundation; \$10,000 to be matched for a sub-acute detox center in Great Falls; funding for Blackfeet and Crow as determined by the Bureau. Monies left will go into the Bureau training unit.

The Alcohol Programs of Montana has met with the League of Cities and League of Counties. The Leagues have agreed to support a user tax on alcohol for treatment and rehabilitation if the Alcohol Programs would request additional tax.

The Addictive Diseases Bureau has agreed to cooperate with a bill introduced on D. W. I. by the Highway Patrol which will require a minimum of eight hours of alcohol education for a person convicted of a D. W. I.

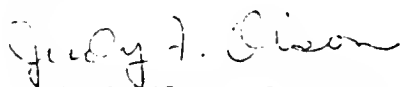
The Department will propose to limit the Galen Alcohol Service Center except as a regional 30-day alcohol program and give each of the other regions \$150,000 to establish a residential program or purchase care wherever they want. The Department also supports the residivism program at Galen and establishing of a youth alcohol treatment program.

The Council received copies of the monthly data reports for September from the alcohol programs. Mr. Murray explained the contents of this report. The Council members requested they receive a copy of this report each month.

It was agreed that the next Advisory Council Meeting would be held the first week in January.

The meeting as adjourned at 1:00 p.m.

Submitted by:

  
Judy F. Olson, Secretary

George Swartz announced that the Department of Health, Education, and Welfare has awarded drug monies to Montana to fund 7 slots. A slot is 365 days of active drug treatment. The total grant could be \$49,000; the federal government would fund \$39,200. Montana has to submit a proposal to NIDA to determine priorities and agencies with whom we propose to contract these slots. After the proposal is approved and Montana comes up with \$8,000 local match money, the federal money will be available.

Mr. Swartz presented a proposal from Albert Leves, Inc. to develop a drug-awareness program for the schools in the Billings' area. He stated that the state does not have money to fund it, but that he felt it was worthy enough that he would try to obtain other sources of funding for it.

Mr. Swartz said that the Bureau was working with the state library to develop a drug information and education section. This should be in place by the end of the year, and then all requests for drug information can be referred to the state library.

Mr. Terry Stanclift stated that the training section of the Bureau has held 7 sessions from May through December, 1976, and directly trained 155 persons. He gave a brief explanation on the courses trained. The certification standards for alcohol were presented. Mr. Stanclift explained how the alcohol standards were established and pointed out the major differences between the alcohol and drug standards.

A section of the evaluation handbook prepared by Touche-Ross was handed out to the Council members. Mr. Swartz explained the use of the handbook, its purpose, and how it was developed.

The Administrative Procedures Act has an approval process whereby the state has to evaluate every program and approve it if the state is to continue funding the program. Mike Murray said that the staff has evaluated every program except Fort Peck. Of the 20 programs evaluated, only Colstrip did not pass the approval process. A budget amendment is in asking for \$136,173 of unexpended funds of last year to help fund the programs. If this is approved, it will give an additional \$40,000 to be used for alcohol contracts.

Mr. Jeff Hill made a presentation on the problems of the Northern Cheyenne and Crow Tribes and asked for additional funds to help them with the severe drug problem they have.

Mike Murray presented a letter from NIAAA turning down a request for a federal grant for the Missoula Employee Assistance Program. The Council agreed to let the state contract expire on December 31, 1976, with no contract renewal recommended.

MINUTES  
OF  
ALCOHOL & DRUG ADVISORY COUNCIL

The Advisory Council met in the Department of Institutions' Conference Room, Helena, Montana, on Friday, January 7, 1977, at 10:00 a.m.

Members Present:

Robert L. Van Horne, Ph.D. -- Chairman  
Martha Herlevi -- Vice Chairman  
Peggy Skelton  
Sharon Pettit

Members Absent:

Senator Larry Fasbender  
Gary Hall  
Katherine Manrainai

Guests:

Kenneth Howlett, Missoula Indian Alcohol and Drug Program

Staff:

Mike Murray, Chief, Addictive Diseases Bureau  
George Swartz, Assistant Bureau Chief  
Paul Babbitt, Prevention and Education Manager

The meeting was called to order by Dr. Van Horne. Ms. Herlevi made a motion that the minutes of the last Advisory Council be approved. Ms. Pettit seconded the motion, and the minutes were unanimously approved.

George Swartz reported that the proposal will be submitted today for 28 slots for drug treatment at Rimrock in Billings. It is a \$60,784 contract with 80 percent being reimbursed by the federal government. The contract for Rimrock is \$40,750, with Addictive Diseases Bureau retaining \$2520 for urinalysis, \$2000 for training, \$1130 for medical consultants, \$10,292 for a half-time salary, \$2536 in indirect costs, and the rest for travel for site visits to monitor and evaluate the program. Rimrock will use the second floor of the Billings Deaconess Hospital for treatment. They have a residential section on this floor. Meals will be eaten in the dining room of the hospital. This contract will contract for 75 percent of a master's level person to head the program. Counseling will be by 15 percent of the other people's time plus 10 percent of Howard Simmons' time as the mental health professional. Dr. Van Horne



asked what the format would be for this treatment. Mr. Swartz replied that the 28 slots are specifically for outpatient, drug-free treatment. They are getting some for more detoxification, but they will be detoxed in the hospital if they need medical detoxification. Rimrock will have the standards of the Federal Registrar to follow, and the contract is now being developed which will include all of the requirements. This will give drug treatment service to the Billings' area and should be in place the first part of February, 1977.

Paul Babbitt reported the department received \$36,000 from HUDA to be used for drug prevention grants. Six mini-grants will be issued to each of the five regions. Announcements of their availability went to the press on December 3, 1976. Applications were sent out upon request. The deadline for receipt of applications is January 10. To date we have received only 2 applications back. The intent of the mini-grants is to create some stimulating ideas for drug prevention activities. When these applications are returned, the Human Resource Board from each region will look them over and establish a priority ranking for all of them from that region. They will be funded on a 10 percent advance with the rest of the money paid on actual reimbursable expenses. Dr. Van Horne asked how the effects of these grants would be evaluated. Mr. Babbitt replied that the programs have been requested to include an evaluation tool in their proposal and that the Human Resource Boards would also be evaluating the effects. Dr. Van Horne said that he would like some feedback when these grants have been completed. The money must be used by June 30, 1977.

Paul Babbitt passed out a booklet on questions and answers on drug abuse. Mr. Murray asked the Council if they thought it would be good public relations to send one to each member of the Legislature. Dr. Van Horne suggested that Senator Fasbender might have some idea of what members of the Legislature should receive the booklet. Ms. Herlevi felt that Health and Welfare should get it. Mr. Babbitt requested a list so that he could mail the booklets out to the appropriate people.

Mr. Murray distributed a list of the approved alcohol programs which indicates the specific services for which each program was approved. He explained that we have received some requests from programs who want to be approved even though they are not receiving state funding. Ms. Herlevi asked how Silver Bow is being funded. Mr. Murray explained that they are a private-care, profit-oriented organization and are sponsored by a corporation that has other such facilities in the United States.

Mr. Murray distributed copies of the Bureau action plan and asked the Advisory Council to review it and submit comments and changes. He explained that his and Mr. Swartz' plans are not included.

Four of the five regional plans are in. The Billings' Region III plan is not in at this time. In the next month a copy of each regional plan will be sent to each Advisory Council member.

Copies of the draft report on the Conference on Alcoholism and Intoxication Act were distributed. Mr. Murray pointed out that the department will be changing some of the areas.

A report from Gary Marbut's Blue Ribbon Committee on Mental Health was distributed. Section 7 deals with alcohol and drug abuse problems as they have identified them. It corresponds closely with the weaknesses identified by the Addictive Diseases Bureau in their report to the Legislature. The Blue Ribbon Committee wants separation of programs for adults and children. It gets into specifics more in the drug area than in alcohol. Dr. Van Horne pointed out that it identifies the problems but not how to deal with them as far as finances go.

Mr. Murray handed out the proposed Legislation of the Alcohol Programs of Montana on House Bill 909. Some of the major changes in the revision are: (1) family members are included for the first time in the treatment and rehabilitation of the alcoholic; (2) family members and prevention are both defined for the first time; (3) the taxes are increased in the back section of the Act on page 7 to 15 percent -- 10 percent would go to the counties with 5 percent for general funds and 5 percent to be spent by the counties in the treatment of alcoholics in that county and 5 percent would go to the Addictive Diseases Bureau to make up discrepancies for sparsely populated counties. It raises tax from 25¢ to \$1.75 on a barrel of beer. Beer has borne the brunt of taxation. Mr. Murray pointed out that the price of alcohol has not risen with inflation. Ms. Herlevi feels that if we tamper with the price of beer it will create more static. Dr. Van Horne pointed out that this is a 5.8 million dollar increase and said he is sure the programs don't feel they will get this. He feels that if we submit a proposal with a more realistic figure we would be more effective.

The Bureau of the Budgets has recommended \$466,219 for alcohol. If we receive what is proposed, we would lose at least 10 alcohol programs which are now funded. In the area of alcohol in the Governor's budget they are recommending \$696,000. This includes the \$200,000 federal money we receive. It recommends no out-of-state travel, no residential services for alcoholics in Regions I, II, III, and V. We would continue with Galen as is. It totally removes all training from the alcohol program's budget. Ms. Pettit asked how the recommendations are reached. Mr. Murray explained that the Bureau submits its budget to the department. The department revised it slightly, and then it went over to the Office of Budget and Program Planning for changes. In the area of alcohol it will severely hurt the current functions. Drugs would continue with Southwestern Montana Drug Program with the \$200,000 and not extend the drug programs elsewhere in the state unless we receive federal funds. Members of the Legislative Finance Committee which will review our budget are: Rep. Harold Gerke, Rep. Art Lund, Rep. Harry Hansen, Rep. Howard Ellis, Senator Elmer Flynn, and Senator Mark Etchart.

Mr. Murray asked if the Council would like to testify at the next public hearings. Dr. Van Horne said he thought it would be useful to have both staff and Council available to testify if they could testify in a knowledgeable manner. He specifically would like more information concerning the nature and support from counties and cities along with the Legislative support. The Addictive Diseases Bureau will prepare statistical materials for the Council to use to testify if the need arises.

Peggy Skelton made a motion that the meeting be adjourned. Sharon Pettit seconded the motion, and it was approved.

Submitted by:

*Judy F. Olson*  
Judy F. Olson, Secretary

## MINUTES

of

### ALCOHL & DRUG ADVISORY COUNCIL

The Advisory Council met in the Department of Institutions' Conference Room, Helena, Montana, on Friday and Saturday, July 29 and 30, 1977, beginning at 2:30 p.m.

#### Members Present:

Robert L. VanHorne, Ph.D. --- Chairman  
Martha Herlevi --- Vice Chairman  
Gary Hall  
Kay Hanrahan  
Sherry Pettit  
Peggy Skelton

#### Members Absent:

Honorable Larry Fasbender

#### Guests:

Ken Anderson, Region V RADRDs, Polson  
Dick Baumberger, Director, Providence Alcoholism Center, Great Falls  
Vic Evered, Director, W MT Regional Alcoholism Services, Inc., Hamilton  
Clint Grimes, Consultant (RADRDs), Region III, Billings  
Ron Hjelmstad, Region II RADRDs, Plentywood  
Don McDonald, Region I RADRDs, Fort Benton  
Larry McDonough, Dept. of Health & Environmental Sciences  
Bob McKimmon, Counselor, Dillon  
Paul Miller, Director, Powell Co. Alcohol Program  
Marie Morton, Director, W MT Regional Alcoholism Services, Missoula  
Danny Peressini, Hill-Top Recovery Center, Havre  
Ron Spurlin, APM Lobbyist  
Harold Schutt, Director, Alcohol Services, Inc., Kalispell  
Jim Weist, Director, Deer Lodge Co. Alcohol Program, Anaconda

#### Staff Members:

Bob Anderson  
Alice Berg  
Paul Babbitt  
Don Holmes  
Mike Murray  
George Swartz

Dr. VanHorne called the meeting to order. Six members were present, one absent; therefore, a quorum. Mrs. Murray Herlevi made a motion to accept the minutes of the last meeting as mailed to the members; seconded and approved.

Mr. Murray called on Bob Anderson who distributed a schedule listing completed evaluations and a tentative schedule for future program evaluations. The handbook used in the evaluation was given to Advisory Council members. The common weakness which evaluated programs have shown is a lack of documentation of services to the client in the records and files. The Bureau is working toward approval on this level (evaluation handbook) for programs with an eye toward future approval by the Joint Commission on Accreditation on Hospitals (JCAH) which will pave the way for third party payments to programs. Dr. VanHorne questioned if programs will be re-evaluated for compliance with recommendations made. Mr. Anderson said they would. Mr. Anderson also stated the handbook would need revisions to keep it up to date from time to time and make it fit Montana's needs and programs. JCAH and insurance payments were discussed.

Mrs. Herlevi questioned the amount of paperwork generated by evaluations and the required reporting with the point made that this was all new to the programs and the problems should be worked out. Mrs. Skelton questioned if the programs were all measuring up to the expectations of the Bureau to which Mr. Anderson responded that the goal for the programs is as follows:

- (1) compliance with HB909 currently
- (2) compliance with the evaluation handbook by next year
- (3) most programs receive JCAH accreditation in approximately 2 - 3 years

A lot of time is involved in evaluation of a program. Nearly two weeks of time is required for an evaluation with the on-site visit and the finalized, written report.

Mr. Babbitt was called on to give a report on the progress of the Mini-grants. He reported 21 \$1,000 grants have been awarded state-wide to be used for workshops on drug prevention, films and material for educational purposes. Dr. VanHorne questioned if there will be any feedback to the Bureau. The grant award was designed with a self-evaluation component included. Three programs' applications were denied - Morning Star in Billings, Missoula Drug Program, Youth Alternatives, Inc., two applications due to not being a non-profit corporation and the Missoula Drug Program, not geared toward prevention.

Dr. VanHorne questioned if this was a one-time project or if the intention of the Bureau is to have similar funds available in the future. Mr. Murray responded that these are ear-marked Federal Formula funds and could be available again. Mrs. Herlevi asked how programs were made aware that funds were available. A news release was issued and in addition, all County Commissioners and programs were notified by a letter that funds were available and the requirements for application.

Regionalization was discussed at this time with the Bureau making the following recommendations:

Region I - The Mental Health Board serves as the alcohol board and spends about one hour on alcohol business every four months when they meet. It was felt a separate board should be developed as the intention is to establish a residential detox and treatment center in eastern Montana with an expenditure of \$300-400,000 involved and a board will be necessary for supervision of these funds.

Region II - Mr. George Swartz discussed the aspects of an intensive evaluation which has been done in this region. The current board position is that they would like to continue; the Bureau recommendation is that we try and work with this Mental Health Board as of the five, they seem to have made the most effort and progress towards becoming a Human Resources Board. Mr. Peressini of Hill-Top Recovery Center and Mr. Dick Baumberger of Providence Alcoholism Center, each felt there was a duplication of services and a loss of funds for administration which otherwise would be available to the programs for treatment of clients. Letters listing reasons were presented to the board members. Dr. VanHorne asked that this problem be studied and a resolution made. Mrs. Hanrahan questioned how this may affect the delivery of services in the region; it is usually the alcoholic who suffers most. Mr. Murray responded that Dr. Mattson had put a time frame of one year on the project and that was about up. Mr. Swartz stated the evaluation results had been given to the Commissioners. Mr. Murray made the point that since the RADRDS program has been in this region the Indian programs have felt they are a part of State alcohol programs which is a positive factor. Further discussion was held and it was recommended the long-term benefits be looked at in this instance and that Mr. Murray present a Bureau recommendation at the next meeting of this board.

Region III - It was felt that regionalization in this region was a failure; an alcohol and drug board should be established. The recommendation was made to table this until the next meeting when further input can be made. Mr. Clint Grimes, consultant for Region III, stated the main service provider for the region, Rimrock, is doing a good job. They work in conjunction with Deaconess Hospital so have accreditation through them. Development of an alcohol program in Lewistown is underway and Miss Herlevi made the observation that Carbon County was sadly lacking in alcohol and drug services as no counselor is available in the area. An alcohol and drug school is scheduled and also a detox training program. The board agreed to table action on this until the next board meeting.

Region IV - The Bureau recommended the State deal directly with the programs in this region. Mrs. Hanrahan asked if adequate services would be provided. Mr. Murray stated he felt the Bureau must support the salary of the current RADRDS position until the Mental Health Center alcohol section can pick it up. Dissolution of ARA and funding as well as administration of the Federal grant funds was discussed. The board accepted the recommendation to eliminate the RADRDS position in this region and contract with the Mental Health board for the position.

Region V - The Bureau recommended to continue as currently established; i.e., a separate board. Mr. Harold Schutt explained that when their region found that a RADRDS would be appointed in the area a board for supervision was formed

and it has been in operation for the past year. Local programs have input to the administration of the region and it has been successful.

Mrs. Hanrahan moved to accept the recommendations of the Bureau regarding regionalization of the programs as follows:

- Region I - contract with a separate board to be formed
- Region II - table action for 30 days or until next board meeting
- Region III - develop a separate board or fill the position with a state employee
- Region IV - discontinue as of June 30, 1977
- Region V - continue with separate board as established

Motion seconded by Mrs. Herlevi; passed.

HB627 and Title 80 Chapter 27 R.C.M. were distributed and discussed. One of the major changes in legislation is that family members can be treated as well as the alcoholic. Treatment plans and files will be made as for a client. Duties of the Department contained in 80-2711 were discussed as well as relationships with Indian reservations and Indian programs. It was agreed that this board would not resolve the problem relating to the latter. Funding methods were discussed and the point was made that funds were dispensed by the Bureau in either fee for services or as a grant.

Certification is a controversial issue at this point. It was hoped to be implemented by mid-August. Discussion.

Funding generated by HB627 was discussed and the budget for Galen. Galen was included in this legislation instead of as in prior years and the appropriation is expected to be \$7.2 compared to \$8.4 for the past biennium. Mr. Holmes stated they have admitted 270 patients this fiscal year compared with 170 for the last. Dr. VanHorne asked how additional funds for programs may affect the Galen program and Mr. Holmes felt it will increase their load as more people would be reached for treatment and more detox required. That has been their experience in the past. It was hoped if an additional detox facility was established in eastern Montana the overload would be minimized for Galen.

Mrs. Herlevi moved Mr. Ron Spurlin be commended for his time, effort and personal expense to get HB627 passed by the Legislature. As a former legislator, she could appreciate the excellent job he had done to promote this legislation. Motion seconded by Mrs. Pettit; passed.

Mr. Raimbarger explained the Alcohol Programs of Montana involvement with HB627 and expressed the hope that funds would support existing programs as well as develop the new. Mr. Peressini stated he felt current programs should be supported at their present level.

Local match was discussed and the point made that with the new legislation this will no longer be a requirement. A letter will be sent to all County Commissioners regarding anticipated funding and requirements for HB627 monies. Copies of this will be sent to board members.

The Bureau can apply for \$190,000 of state or federal funds again and is the Bureau recommendation these funds be used for education/prevention programs.

Cities receive a percentage of the liquor tax monies under HB627 but it is the general feeling of the programs and the Bureau that cities will be reluctant to use these funds for alcohol prevention or education. They will be funnelled towards police, etc. This may be a goal for the programs to work toward -- securing these funds for alcoholism treatment. Mr. Hall stated it seemed to be the consensus of opinion of the board that a grant be submitted for \$190,000 to be expended on:

- (1) Identification of the police department's role in transportation of public inebriates;
- (2) Since the public inebriate is still visible in the community and since merchants, public officials, and the general public continue to call upon the police to "handle" them, the Addictive Diseases Bureau needs to be sensitive to the needs of the law enforcement community.

The Addictive Diseases Bureau should fund a definitive study on the entire question of protective custody -- its nature, intent, and use.

The Addictive Diseases Bureau should cooperate with LEAA and other law enforcement agencies to develop model implementation guidelines for the use of police and sheriff departments.

The Addictive Diseases Bureau should establish a cooperative task force with the Association of Chiefs of Police and sheriffs to develop a study on the vulnerability of police officers and deputies in handling public inebriates.

The Addictive Diseases Bureau should establish a cooperative study group with other interested agencies to investigate the nature and use of substitute charges to circumvent the decriminalization provisions of the Uniform Act.

- (3) The emphasis on voluntarism is a necessary safeguard to the civil rights of the public inebriate. At the same time, the complete freedom of an individual to leave treatment on his own discretion tends to transplant the revolving door syndrome from the jail drunk tank to the alcohol treatment program. Effective means of dealing with this population need to be explored from several stances.
- (4) The stated purpose of the Uniform Act is to remove public inebriates from the criminal process and to bring them into treatment. There is an implication that this will assure quality care to the alcohol and alcohol abusers who enter into treatment systems. Credentialing mechanisms (licensing, certification, and accreditation) are tools which will aid in assuring that the best possible conditions exist to provide quality care. The Addictive Diseases Bureau should finalize and implement the alcohol credentialing system.



George Swartz informed any board members who may be able to attend a training session which will be held in Missoula May 26 and 27. Information will be sent to board members who indicate an interest in attending.

A discussion of Morning Star program was held and the point made their funding will be up in November 1977. Lighthouse was funded by the past legislature for the next biennium. Nationally, Lighthouse is a highly rated program which would have been a great loss to the State had it been cancelled. It was announced that Darryl Bruno, presently an accountant with the Department, has been appointed Administrative Director for the Southwestern Montana Drug Program. He had been the accountant for SMDP since the early inception of the program so he is cognizant of the administration of the program. Mr. Murray also announced that Terry Stanclift, Training Unit Supervisor, and Bob Anderson, Program Evaluation and Reporting Manager, have been named Outstanding Young Men of America for 1977. Rod Gwaltney, Training Officer, has been invited to attend a National Institute of Drug Abuse planning conference to give input from a rural point of view. He is one of 25 persons selected nation-wide for attendance at this conference.

It was agreed the meeting be adjourned at this point and re-convened at 9 a.m. to transact the balance of the business before the board.

#### Saturday 9 a.m.

All six board members were in attendance as on the prior day and the meeting was convened at 9 a.m.

Mr. Zanto, Director of the Department of Institutions, was in attendance and spoke to the group. He stated the Bureau would be elevated to Division status in the near future and the vacancy on the board soon would be filled.

Mr. Murray gave budget details and Dr. VanHorne requested that the Bureau use its judgement on adjustments with the statement from Mrs. Herlevi that programs needing upgrading to meet Department of Health standards for fire, etc., be granted. This was made into a motion and seconded by Gary Hall; motion passed.

A discussion on relationships with the programs was held and supervision of same after HB627 funds are disbursed. The Bureau/Department will have to certify programs and issue approval before county funds can be expended. The board recommended the Bureau require programs submit operational plans for reviews as part of the program approval process.

The letter Representative O'Keefe sent to Mr. Murray was discussed and the amendment referred to. Program operational forms were discussed and note made that no match will be required. It was the boards' preference that unnecessary details in the form be eliminated but the Bureau use its judgement in this area. The board will review operational applications from the programs at the next meeting. Funding for the interim period until county funds become available for distribution was discussed. It appears the state can "loan" funds to programs where necessary, as it may be October before some counties have the funds available.

A Residential Treatment Center at Glasgow Air Force Base was discussed. Medical coverage and legislative intent was discussed and the board felt they would recommend that due to possible lack of medical supervision, stigma of being associated with a program of the nature of the one currently at the base, remoteness of the facility they would recommend that two facilities be funded - one in Glasgow Deaconess Hospital and one in Miles City or that area - rather than a single facility at the base. Mr. Spurlin pointed out the intent of the legislation was to provide the broadest based assistance to alcoholics as was possible. The alternative to the base recommended by the board would be that Glasgow have a center for 15 slots and Glendive/Miles City area a center for 15 slots.

A discussion was held on the procedures required by programs for application of funds for residential treatment facilities. Mrs. Hanrahan moved that a total award not to exceed \$400,000 be made to establish a residential treatment program in eastern Montana. Mrs. Herlevi seconded the motion; passed.

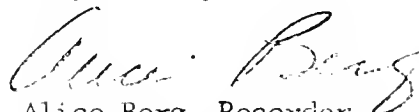
Mr. Murray stated that in the distribution of liquor funds, eastern Montana will be short of funds in comparison with the rest of the State. Mrs. Pettit made the motion that the Bureau fund programs with documented need until the HB627 funds can become available to the counties for disbursement. Mrs. Herlevi seconded; passed.

Program development and development of Bureau priorities were discussed and the latter tabled until a future meeting.

Mr. Murray announced representatives from the Federal level would be here to review the State Alcohol Plan in June. The next meeting date was set for June 2 and 3 beginning at 7 the evening of the 2nd and a second meeting June 27 at 2 p.m. to review the Drug Plan and the Alcohol Plan with NIDA & NIAAA people.

Mrs. Pettit made the motion to adjourn; seconded by Mr. Hall; passed.

Respectfully submitted,

  
Alice Berg, Recorder

MINUTES  
of  
ALCOHOL & DRUG ADVISORY COUNCIL

The Advisory Council met in the Department of Institutions' Conference Room, Helena, Montana, on Thursday, June 2, 1977 at 7:15 p.m.

Members Present:

Robert L. VanHorne, Ph.D. — Chairman  
Martha Herlevi — Vice Chairman  
Kay Hanrahan  
Sherry Pettit  
Peggy Skelton

Members Absent:

Gary Hall  
Senator Larry Fashender

Guests:

Dick Baumberger, Providence Alcoholism Center Director, Great Falls  
Don McDonald, Region II RADRDS, Fort Benton  
Larry McDonough, Health Planning  
Danny Peressini, Hill-Top Recovery Center Director, Havre  
Joe Plumage, Browning  
Brenda Running Fisher, Blackfeet Tribal Alcoholism Program, Browning  
Jim Scott, Alcoholism Rehabilitation Association Director, Helena  
Jon Tovson, Cascade City-County Alcohol Program Director, Great Falls

Staff Members:

Mike Murray  
Barry Potter, Consultant  
George Swartz

Minutes were reviewed and the correction made to change Mrs. Herlevi to Miss Herlevi. Miss Herlevi moved the minutes be approved as corrected; second by Sherry Pettit, motion carried.

Dr. VanHorne introduced Mr. Al Goke, Chief of the Highway Safety Division, who presented the need for funding the state alcohol lab. It was reviewed by the legislature and approved as a lab, but not funded. An annual operational budget of \$50,000 is required and its purpose is to enforce the implied consent law relating to DWI. Mr. Goke requested an indication of the feelings of the Board members towards the submission of an application for funds from alcohol treatment and rehabilitation monies. After a discussion the Board indicated they would be receptive to review a proposal from Mr. Goke if he cannot find funding from any other source.

Mr. Goke also explained the new program is called the "County School." He indicated implementation would be held up until after July 1, 1977 when funds become available. The Highway Patrol has been developing a system whereby an individual convicted of a DWI would be given the option of attending this school when the program is operational. There are some bugs to work out in the program and with the cooperation of the Highway Patrol, Department of Justice, Department of Institutions, Addictive Diseases Bureau, to provide training to program providers on the DWI modality. Some funding may also be available so State approved programs could contract on a fee for services basis with counties to provide a DWI program.

Mr. Murray reported on the current status of the Eastern Montana Residential Alcohol Treatment Program. The application is being developed in cooperation with Health Systems Agency and the Health Department to include the Certificate of Need review process by a sub-area council in eastern Montana. The Advisory Council indicated their desire to participate in the sub-area review when it takes place and recommended the review be held the week of September 19, 1977, if possible. The Council will act as resource persons.

The cash flow problems for the Addictive Diseases Bureau were reviewed by Mr. Murray who indicated the tax revenue funds at the county level from HB627 will not be available from the counties until sometime in October with a possible starting date of November 1, 1977. To fund programs at their current level approximately \$100,000 will be required. The Council recommended the ADB fund programs at their current level until October 31, 1977.

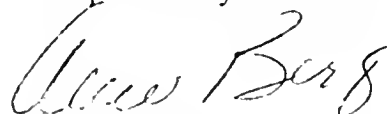
Region III Plan was reviewed. The Plan provides for establishing an area advisory council to be chaired by Miss Herlevi of this Council which would meet semi-annually or on an as-needed basis. Kay Hanrahan made the motion to accept the Region III Plan; seconded by Sherry Pettit; passed.

Copies of the Uniform Detox application were distributed to Board members and the work plan outlined for FY'78 was reviewed. After a lengthy discussion the Board tentatively adopted the following priorities for the Federal alcohol formula funds:

- (1) Maintain continued funding of existing alcohol programs;
- (2) Provide continued funding for regionalization which has Council approval;
- (3) Develop a women's alcohol and drug prevention treatment and rehabilitation task force;
- (4) Fund youth prevention;
- (5) Fund an urban Indian alcohol program;
- (6) Develop a youth needs assessment.

The next Council meeting is scheduled for June 27 at 2 p.m. in the Department of Institutions Conference room. At that meeting the Council will finalize priorities for the alcohol plan and review the work program for the State Drug Plan.

Respectfully submitted,

  
Alice Berg

M I N U T E S  
of  
ALCOHOL & DRUG ADVISORY COUNCIL

The Advisory Council met in the Department of Institutions' Conference Room, Helena, Montana, on Monday, June 27, at 2:00 p.m.

Members Present:

Robert L. VanHorne, Ph. D. - Chairman  
Gary Hall  
Joseph Plumage

Members Absent:

Senator Larry Fasbender  
Kay Hanranan  
Martha Herlevi  
Sherry Pettit  
Peggy Skelton

Guests:

Boyd Andrew, Boyd's Guest House, Helena  
Dick Baumberger, Providence Alcoholism Center, Great Falls  
Don McDonald, Region II RADRDS  
Berna RunningFisher, Flackfeet Tribal Alcoholism Program, Browning

As the three members present did not constitute a quorum no business could be transacted. The following discussion was held:

The Bureau intends to advertise in major Montana newspapers the availability of alcohol funds during the weekend of July 10 with the applications due September 2. They will be reviewed by Bureau personnel the week of September 5-9 and mailed to the council along with the Bureau recommendations the week of September 12. The Council review will take place at the September meeting expected to be during the week of 19-23 which will be held in Eastern Montana. The possibility of meeting in Helena for this review and then taking a State plane to Eastern Montana was discussed and may be a possibility.

It was agreed that programs operating with County funds would be expected to meet the same criteria as State funded programs.

The Valley Industrial Park, Inc. correspondence was discussed. Letters stating Legislative intent were presented for Council review. Mr. Murray stated that the Director of the Department of Institutions, Larry Zanto, does intend to advertize the availability of funds for an eastern Montana treatment facility(s) as discussed at a previous meeting.

The alcohol lab funding request from the Department of Justice was discussed and it will be reviewed along with the other applications at the meeting in September. The consensus of the members present was that it was a valid project and the application will be reviewed along with other new alcohol applications at the September meeting.

Dick Baumberger questioned the cut in the interim funding for Cascade County. Mr. Murray explained that the interim funding grants were a "hold the line" budget and would not fund new positions. New positions must be held up until the November 1, 1977 grants are available.

A request for funding from Galen State Hospital AT & R was reviewed along with the report for the summer alcohol school session recently held at the College of Great Falls. Dr. VanHorne felt funds expended for projects like summer schools and training sessions gave a better return for the investment than anything depending upon TV to reach viewers. The budget for the summer session was \$5,000; the movie budget would be \$9,273. The members present requested Mr. Holmes submit a proposed script for review by the Council. Dr. VanHorne also expressed his interest in reports similar to the one on the summer school. He felt this gave the board very useful information and allowed them to judge the results of projects. He asked that concise reports similar to the one on the summer school be given to the Board and was especially interested in the results of the mini-grants projects.

Alcohol priorities were finalized:

ALCOHOL PRIORITIES  
FY '78

1. Continue Regionalization .....	\$110,000
(Regions I & V Staff; program related projects Regions II, III, IV)	
2. Continue Alcohol Management .....	\$ 20,000
Information System (12 mos. secretary; 6mo. project manager and operational costs)	
3. Urban Indian Alcohol Program .....	\$ 30,000
4. Develop Alcohol Prevention System .....	\$ 22,500
5. Woman's Issue Task Force .....	\$ 10,000
6. Youth Issues Task Force .....	\$ 7,500
	TOTAL \$200,000

Dick Baumberger questioned the possibility of Title XX funding becoming available to alcohol programs. Mr. Murray stated they are being utilized by SRS and it is anticipated none would be available for alcohol program funding. He questioned if 627 funds could be used for capital expenditures and Mr. Murray agreed they could.

A memo regarding alcohol /drug counselors for the correctional institutions to Mr. Murray from George Swartz was discussed and it was agreed the project should be funded with the \$5,450 for match money for the Federal IDAA grant and \$15,000 from the State Drug Abuse funds. The Prison at Deer Lodge would likely be served from this office, Swan River from the Polson office, and Pine Hills contracted through the Mental Health Center in Miles City.

The FY '78 Drug Plan Priorities and Significant Features report was discussed with Barry Potter, consultant for the Bureau.

Julie Wagner and Marie Harlan from the Gallatin Council on Health and Drugs who administer the Gallatin County Families are Responsible (FAR) program discussed their request for funding this project. The feeling of the members present was this was a good use of drug funds.

Mr. Potter discussed the status of the State Drug Plan and stated it would be similar to prior years with emphasis in a few different areas. He reported that Mr. Arnold Mills, National Institute of Drug Abuse, will be in the office for a couple of days to assist in development of the Plan.

NIDA involvement with programs was discussed. Mr. Plumage questioned the validity of the Morningstar program. It was pointed out that the Morningstar grant is a demonstration grant and therefore does not require compliance as some other grants do. Dr. VanHorne questioned if there was a penalty for programs who do not meet their goals and objectives. Mr. Murray stated if identified by evaluation, funding could be reduced or the entire grant or contract terminated; however, neither generally occur.

The involvement of the Health Systems Agency with the State Plan was discussed. It is expected that in the future additional involvement with this agency will be necessary.

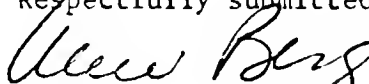
Mr. Murray stated there would be someone from NIAAA available to review the State Alcohol Plan Wednesday, August 3 - this date was set for a Council meeting at 10:00 a.m. in the Department Conference Room. Boyd Andrew announced that Neil Scott from the National Council on Alcoholism will be in the area August 5 with the intention of assisting a group with the development of a State Alcohol Council.

Mr. Murray stated there will be a public hearing held on the State Plan prior to its being sent to NIAAA.

Mr. Plumage questioned the decision to discontinue the RADRDS position in Region II. He felt it gave the Indian programs a sense of belonging and he expressed the desire to continue the project. Mr. Murray stated he would develop a proposal for review by the Council to continue the project in some form.

This covered the items before the Council at this time and the meeting adjourned.

Respectfully submitted,

  
ALICE BERG, Secretary

## MINUTES

### ALCOHOL AND DRUG ADVISORY COUNCIL

The State Advisory Council on Alcohol & Drug Abuse met in the Department of Institutions Conference Room on Tuesday, August 12, 1977 at 10:00 a.m.

#### Members Present:

Robert L. VanHorne, Ph.D. — Chairman  
Martha Herlevi — Vice Chairman  
Senator Larry Fasbender  
Gary Hall  
Katherine Hanrahan  
Joseph Plumage  
Peggy Skelton

#### Members Absent:

Sherry Pettit

#### Guests:

Don McDonald, Region II RADRDS  
Berna RunningFisher, Blackfeet Tribal Alcoholism Program, Browning

#### Staff:

Mike Murray  
Barry Potter, Consultant  
George Swartz

#### Region VIII Staff, Denver:

Dr. Stan Mahoney  
Ms. Naomi Kennedy  
Mr. Ted Fasso

Dr. VanHorne opened the meeting. The minutes of the July 27 meeting were discussed and accepted on the motion of Miss Herlevi. The State Alcohol Plan was presented.

Mr. Fasso, Coordinator, Alcohol Prevention, Treatment & Rehabilitation Programs, spoke briefly on the Plan information review prior to this meeting. He stated the funding for the plan is on an October 1, 1977 - September 30, 1978, fiscal year. Also, the HEW priority areas for program emphasis include women and youth.

Ms. Kennedy stated the Plan did not contain the A-95 review as required but the State has made great improvements over the years and the general direction of the Plan was good. She felt the summer workshop was an



effective program and would like to see it continue in future years and possibly expand. She questioned the figure in the report for "medical professionals" and it was explained that the figure would include nurses as in most treatment facilities in the State, nurses, rather than physicians see clients in the emergency room at the treatment facilities.

Certification was the next area of discussion. Mr. Plumage questioned the percentage of time spent in counseling clients and felt it should be 90% of the counselors time. Mr. Fassio responded that 50% was a more reasonable percentage as the paperwork was a necessary item and was time consuming. A program with a direct patient activity of 50% meets any Federal standards. Section 8, Region I, women's plan was discussed. Mr. Swartz stated 10% of clients are women; 43% of the program counselors are women. Mr. Murray reported on the State Task Force for Women and also the Regional Coalition of which Norma Murphy of this Division is the State representative. It is planned that a modality for treatment of women will be developed and training emphasis will be on treatment for women. Child abuse and neglect as well as the battered wife syndrome was discussed. This Division and the Department are coordinating efforts with the Social Rehabilitation Services Department in these areas as well as with the Corrections Division to some degree within the Department. Miss Herlevi brought in the name of Dr. Bill Roder of St. Mary's Hospital in Los Angeles, California, as a person who had done research and study in this field.

Senator Fasbender questioned the necessity of the IEAA grant for \$3,000 for an additional study of the battered wife syndrome with the response from Mrs. Hanrahan that she felt the public involvement was most valuable. She reported briefly on a meeting held recently in Glendive which proved most informative and made people realize the problem is a local one, not one that happens elsewhere. This was discussed. It was pointed out that new programs do not need development, a re-direction for existing ones or training so that the problems can be handled and knowledge of available resources.

Section 8.1.17 - Eastern Montana. Social problems involved with the coal development was discussed and the involvement of private industry noted. Continued efforts for involvement of business people on boards, etc., is to be encouraged, developed and utilized to the extent possible.

Mr. Murray talked about a program called Operation Mainstream which was quite successful while in operation. The Rocky Mountain Development Council had contracted to have clients work on projects for the community and extensive work was done at the Lewis & Clark County Fairgrounds. It was felt by the group that projects of this type are very worthwhile and some special interest development should be done.

Ms. Kennedy discussed the Hill-Top Recovery Center as included in the Plan and questioned the 30-day residence, if that was longer than average. Mr. Fassio felt there may be a problem with the "revolving door" at the facility. This led to a discussion on the institutionalization concept and the point made that Adams County, Colorado, has a facility called Washington House which has a 5-day in-residence/intensive outpatient counseling modality that is very effective. It seems to put the responsibility for a "cure" on the patient, not on the program, which is where it has to be.

The Regional/County philosophy was questioned by Mr. Fassio; Region III seemed to have a good Indian project plan. A discussion was held on the Regional vs the County function and how other states in the Region were having some difficulties with the concept and it probably would be something that would never be resolved completely, but something that needed refinement, depending upon the circumstances being dealt with. Dr. Mahoney stated the trend is toward Regionalization, there is no way feasible to provide comprehensive alcohol services on a County basis. Some regionalization is economically essential for operation of a program.

The arrest rate of Mexican Americans in Region III was questioned. Senator Fasbender stated Great Falls has discontinued their practice of arrests for drunkenness. This was discussed. Region IV had some areas which need to be updated; Region V is using the Regional approach to some identified needs. Efforts toward helping the urban Indian were commendable; the Community College in Kalispell seemed to be very effective (the point was made that it seemed smaller, local schools of this type were more responsive to community needs and should be utilized to the fullest extent possible).

Dr. Mahoney agreed with Mr. Fassio's statement that an introductory statement in the Plan regarding Regional input should be added to tie it together. Mrs. Hanrahan stated that in the future an effort be made to standardize information.

Ms. Kennedy stated the State has lots of work to do; care should be taken that all of the eggs are not in the educational basket. Mr. Fassio commented that at the Plan now stands it is difficult to evaluate and hard to measure. Prevention skills need to be developed, be more specific. Strengths of the Plan included the active participation of the Board and citizens was excellent. It had a Statewide impact and set priorities; budget had been allocated. The inclusion of the Alcoholism and Montana Indian People, Toward an Off-Reservation Solution by C.E. Grimes was informative; resources were identified. Indian alcoholism programs seemed to benefit from the Regionalization which was a good point. Training was identified.

Weaknesses included the County/Regional problem, women's programs were not inclusive, the problem with alcohol/mental health umbrella and needs based on extrapolation. Also not covered in the Plan was an Affirmative Action Plan. Basis for selection of State Advisory Council members should be included. It appeared the Regional plans were written sometime prior to submission of the Plan; questioned the reason for this. Management/business inclusion on the Council is desirable. Counselor certification needs further refinement, and an organizational chart should be included.

Mr. Fassio pointed out the Department of Transportation has funds for vans to programs which qualify. This was of interest to the group and will be investigated. Ms. Kennedy felt volunteers from AA should have a value; the Plan

should have a 30-day period of public availability prior to submission. She also raised the question on the feasibility of a winter session instead of or along with a summer session. Also questioned again was the length of stay of clients in some treatment facilities.

Points made by Dr. Mahoney were: date Plan is to be submitted is July 15; A-95 review is essential before any official action can be taken on the Plan; the Affirmative Action Plan must be included. Mr. Murray took exception to this as he felt the Department of Institutions has a plan as well as the Division covered by one under the State Merit System Council; he felt it was unnecessary duplication of effort. Dr. Mahoney stated the Plan should include a reference where this Affirmative Action Plan is available. As of January 1, 1979, the Federal people will be examining Plans for age discrimination. This should be kept in mind. He also questioned if University or college education is applicable to the needs of the State, i.e., are those educational units receptive to community needs and willing to offer courses to fill these community needs.

At this point Mr. Fassio inquired as to the status of Galen AT&R. It was explained they are funded by the alcohol tax as part of the Alcohol & Drug Abuse Division and are under the administration of Warm Springs State Hospital.

Terry Stanclift, Training and Certification Supervisor, entered the meeting. Dr. VanHorne questioned the funds available for certification up-grade and if it is possible to continue. Mr. Stanclift explained the grant under which this project is funded and the dependency upon the grant for the necessary funds. Berna RunningFisher questioned if there would be a certificate for Administrator's. Mr. Stanclift explained that anyone applying would be certified at a Class II level. For the time being, that is the only level which certification will be issued. Certification of Administrator's will be tabled until assessed further. Counselor Certification standards will be included in the Montana Administrative Code by October 26, 1977 and become effective as of that date.

Mr. George Swartz entered the meeting and at this time gave a report on the status of the DWI bills (HB251 and HB355) implementation. A program should be available to all courts in the State September 1, 1977. It is anticipated that a \$50 charge will be assessed the courts and offenders will be required to attend a minimum of 8 hours of schooling. This will include first offenders as a preventative measure. The habitual offenders will be handled a little differently. Berna RunningFisher questioned the inclusion of the Indian reservations. Mr. Swartz responded that this question is unanswered at this point - he assumed if the reservations wanted coverage under the program it would be their prerogative - the program is available, instructors will be certified in the immediate future. Mr. Swartz also spoke on the Division's application of an LEAA grant for three substance abuse counselors to cover Swan River Youth Forest Camp, Pine Hills School for Boys and Montana State Prison. Southwestern Montana Drug Program has been counseling the girls at the Mountain View School and has done some work at the prison in the past. These positions would be counseling at the institutions.

The application of the Department of Justice for the Alcohol and Abused Substances Unit (DWI lab in Missoula) for \$39,776 for the period October 1977 through June 1978 was discussed. As the Council was in favor of the project but realized there was a limited amount of funding available, Mrs. Hanrahan made the motion to fund them for the interim period (one-third) of the request with the recommendation that other sources of funds be developed for the future. Motion seconded by Miss Herlevi. Passed.

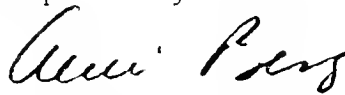
A proposal from Toole County was presented. Some of the elements in the proposal had been addressed by prior Council action and it was the opinion of Division staff as the goals and objectives were not measurable it not be funded. Senator Fasbender made a motion funding be denied, second by Mrs. Skelton. Motion carried.

Changes in the State Plan were discussed as well as the feasibility of a Health Systems Agency Board members' inclusion on the Council. The treatment facility in Eastern Montana was discussed and it was recommended by the Council that Clint Grimes be contacted to assess the potential of proposals.

Mr. Hall made the motion to adjourn; motion seconded and carried.

The next meeting will be the third week in September.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Alice Berg".

Alice Berg, Secretary

## MINUTES

### MONTANA ADVISORY COUNCIL ON ALCOHOL & DRUG DEPENDENCY

The State Advisory Council on Alcohol & Drug Dependency met in the Department of Institutions, 1539 11th Ave., Helena, on September 19 and 20, beginning at 1:30 p.m.

#### Members Present:

Robert L. VanHorne, Ph.D. — Chairman  
Martha Herlevi, Vice Chairman  
Katherine Hanrahan  
Joseph Plumage  
Peggy Skelton

#### Members Absent:

Senator Larry Fasbender  
Lt. Gary Hall

Sherry Pettit -- in Washington, D.C. to represent Montana  
at a NIAAA meeting.

#### Staff:

Mike Murray  
George Swartz

Dr. VanHorne called the meeting to order. Minutes of the past meeting were approved; motion by Miss Herlevi, second by Mrs. Skelton.

Mr. Murray spoke on the outcome of a hearing before the Legislature's Administrative Code Committee. This committee was not of the opinion certification of counselors could be implemented without prior legislation, thus, the plan has been shelved unless a voluntary system can be developed. Certification was discussed and the point made by Mr. Swartz that it appeared that NIAAA would require certification within a year or two. The general consensus of the Council was that voluntary certification should be encouraged.

The Council's attention was called to the minutes of the last meeting. The recorder interpreted "interim period" in the discussion and motion regarding the funding for the DWI lab to mean the period of time requested in the application. After discussion of the aspects involved, Mrs. Hanrahan made a motion to fund the DWI lab for the period October 1, 1977 through June 30, 1978 in the amount of \$39,776. Second by Mrs. Herlevi. Motion carried.

Program funding applications were discussed. Dr. VanHorne questioned the amount of money available and Mr. Murray explained that approximately \$300,000 should be available. This is a larger amount than anticipated due to the lateness of the eastern Montana residential facility being established. It is doubtful the entire \$400,000 allocated could be spent in the

six month period remaining of the fiscal year.

Mr. Plumage questioned the provision of services in Mineral county. This was discussed. County participation under the new funding procedures were discussed. Dr. VanHorne questioned the involvement at this point in time of the Superintendent of Public Instruction's office in the school curriculum as it pertains to alcohol and drug prevention and education. Mr. Swartz explained the alcohol program prevention and education proposals submitted.

Funding for Providence Alcoholism Center was discussed. The point was made that funding is channeled through the Cascade City-County Health Department. Discussion.

The Council broke into regional task forces at this time to meet with members of the staff for review of the grant applications. The meeting reconvened at 9:00 a.m. September 20.

The meeting reconvened at 9:00 a.m. with the same members in attendance as on the prior day.

Mr. Plumage stated Rimrock Guidance Foundation applications covering the majority of Region III should be reviewed at the next meeting as he was unable to assess the applications due to the lack of adequate time for review. As the remainder of the Council was in agreement, these applications will be tabled until the October 12-13 meeting.

Program applications were discussed as follows:

Region I - Mrs. Hanrahan

District I - Since the city of Scobey handles the books, bond insurance may not be necessary, ADAD staff will make a determination. Prior to contract program must rewrite goals and objectives in measurable terms. Program must submit justification for the education consultant position prior to funding. Recommended State funding of \$24,062; total approved budget \$66,675.

Tri-County - Well written proposal. Recommend reducing office supply category to \$400. Recommended State funding, \$7,854; total approved budget \$15,331.

Custer Co. - Objectives A & B of Goal I not measurable and must be rewritten. Advisory Council would like to review programs prevention and education package. Salary of Counselor/Director higher than similar programs in the region and Council wants any proposed increases justified and submitted for review prior to local program action. Total approved budget \$20,937.

Rosebud Co. - Well written proposal. Recommend State funding \$5,107, total approved budget \$20,275.

District II - Well written proposal. Council felt salaries not commensurate with work performed and recommended counselor's salaries be increased with State funding (total increase \$4,238). Recommended State funds \$16,180 total approved budget \$56,650.

Region II - Dr. VanHorne

Hill-Top Recovery - No amount available as some budget categories need to be clarified and adjustments made; Glacier and Pondera Counties input is needed and the client fees schedule is questioned. Recommended State funds \$62,448, total approved budget \$131,795.

Blackfeet Tribal Alcohol Program - 12 month budget submitted; the Data Coordinator position was deleted as it was felt if this was a NIAAA requirement it should be NIAAA funded; coverage for satellite offices was discussed. Budget request reduced to reflect 8 month funding. Council recommended funding outreach \$11,780; travel \$1,080; training \$1,350. Recommended State funds \$14,210, total approved budget \$117,580.

Cascade City-County - Bonding requirement questioned; contracts for services not included; Providence budget items questioned. Discussion held. Council agreed with request and submitted to Program for additional material. Question raised if City-County can receive funds as they are not an approved program. No State funds; total approved budget \$173,287.

Fort Belknap - 12 month budget submitted; secretary position cut; training budget \$1,500; State funds \$9,364, total approved budget \$127,545.

Region III - Mr. Plumage

Northern Cheyenne - Not approved program; \$26,841 contingent upon State approval. Insurance coverage is necessary; goals and objectives of the program are well done.

Central MT Family Services - Goals and objectives need strengthening; insurance coverage necessary. DWI instructor was deleted, can be funded under another grant. Recommended State funds \$15,566, total approved budget \$36,456.

Region IV - Dr. VanHorne

SW Mental Health & Alcohol Services - comprehensive budget; county and other funding appears adequate for three additional positions; due to lack of budget justification no State funds obligated. Total approved budget \$268,801.

Lewis & Clark Alcohol Program - No State funds if County Commissioners adhere to 9/15/77 letter awarding all County funds to SW Mental Health & Alcohol Services as the designated County program. Total approved budget \$22,045.

Deer Lodge County - Well written proposal. Recommended \$4,515 State funds, total approved budget \$22,045.

Powell County - Bond required; signature of Board Chairman required. Recommended \$19,339 State funds, total approved budget \$26,446.

Butte Indian Program - Not an approved program; recommended training fund assistance to staff of \$2,000, not necessary to contract. NIAAA funding of \$42,385; program eligible for Urban Indian Program application.

Region V - Mrs. Skelton

CEDS (Missoula) - Not an approved program; presented two proposals, one for a half-way house and an out-patient facility. Discussion; should funding become available the half-way house would have priority for State funding.

Missoula General Hospital - No State funds requested; not an approved program. Recommend Missoula County set aside \$41,980 for program. Program will be considered later as funds become available. This will be a 14-bed residential program. Total approved budget \$170,910.

W MT Regional Alcoholism Services, Inc. - Has been divided into Mineral, Ravalli and Missoula Counties. Ravalli County State funds \$5,186; Sanders County State funds \$73; Missoula County State funds \$5,259. Travel and one Missoula County prevention/education staff position cut. Total approved budget \$105,340.

Missoula Indian Program - New program; County funds \$1,250; State funds \$850. Recommendation that if the County does not fund, the State fund \$2,100 (travel \$500; training \$1,600). Total approved budget \$69,600.

Lincoln County - Objectives must be re-written in measurable terms; projector eliminated \$935. Recommended State funds \$36,649, total approved budget \$58,174.

Sanders County - New program formerly under the Flathead Tribal Program. One counselor position cut, contracted accounting position cut; discussion centered on 85% of the County population being alcoholics. Objectives must be re-written in measurable terms. Recommended State funds \$14,735, total approved budget \$23,133.



NW MT Alcohol & Drug Services, Inc. - County funds; current low client staff ratio (4-1); non-Indians served. Discussion. Council recommended Lake County alcohol funds be used to open and operate an out-patient alcohol program in Polson for non-reservation county residents. Total approved budget \$306,598.

Flathead Alcoholism Program - Appears to be adequate county funds; experimental residential detox facility may be funded later. Program is interested in visiting the Adams County facility in Denver with the Council. 12 month budget submitted. Total approved budget \$234,526.

Mr. Plumage made the motion that the above programs be funded as recommended. Second by Mrs. Skelton. Motion carried.

Mrs. Skelton moved the Rimrock proposals be reviewed at the next Council meeting, October 12 & 13. Second by Mrs. Hanrahan. Motion carried.

The Department/Division involvement with the Women's Task Force was discussed and the first meeting scheduled for October 11, 1:30 p.m. in the Department Conference Room. A tentative date of October 2-5 was set as a possible date for a visit to the Adams County facility in Denver.

The October 12-13 meeting will convene at 9:00 a.m. There will be a Certificate of Need review for an eastern Montana treatment facility on the 13th with HSA at 11:00 a.m. Miles City Holy Rosary Hospital and the Valley Industrial Park will be contacted to make a presentation on their proposals to the Advisory Council prior to the HSA meeting.

Mr. Murray stated there was the possibility of additional funds from the federal level if we submitted a second State alcohol plan. The eastern Montana residential treatment facility was discussed with Dr. VanHorne stating it appeared the Board will examine the proposals and funding would become available for construction, etc., prior to January 1978. Mrs. Hanrahan questioned if Mr. Grimes could be secured to give the Council an evaluation of the needs, recommendation for the center(s) and meet with the Council October 12 with this information.

Mr. Swartz reviewed the contracts to furnish a drug counselor to the Pine Hills School for Boys, Swan River Youth Forest Camp and Montana State Prison. Mr. Bob Frye will work through the Mental Health Center in Miles City for Pine Hills, Mr. John Brekke will work at Swan River, employed by Region V Drug and Alcohol Board, and Bob McKimmon will be employed by the Division and work at the prison.

Discussion was held on the urban Indian proposal, the suggested contract for a study on the protective custody/drunken law enforcement procedures and the proposal for the university system to implement a training program for police officers. Dr. VanHorne stated proposals should be received by October 31. Discussion of the revolving door alcohol problem. Mini-grant applications will be due October 21 for review at the November 8 meeting.

Mr. Swartz explained the progress of the DWI schools. These operational plans will be due October 31 for the November 8 meeting. Regions I and V have RADRDs as yet, continuation grant applications will also be reviewed.

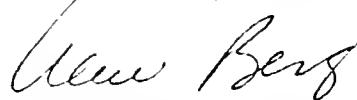
Mrs. Skelton expressed a desire to visit programs; the November 8 meeting will be scheduled at the site receiving the Certificate of Need in eastern Montana.

Mrs. Hanrahan questioned the "occupational program" the Department is involved with. It was explained by Mr. Swartz it is kept on a low profile, and maybe needs to be "advertised" at least in the State phone book. It has been effective in cases where it has been used.

Mr. Murray reported on a contact with the "Montana Citizen" for an ad in the State Chamber of Commerce magazine. He has also requested the COMP Care Corporation of California to submit a proposal on prevention education awareness program. These issues were discussed with the Council and the Council is in agreement with staff action taken.

Mrs. Hanrahan moved the meeting be adjourned. Second by Miss Herlevi.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Alice Berg".

ALICE BERG, Recorder

## MINUTES

### MONTANA ADVISORY COUNCIL ON ALCOHOL & DRUG DEPENDENCY

The State Advisory Council on Alcohol & Drug Dependency met in the Department of Institutions Conference Room, 1539 11th Ave., Helena, on October 12, 1977 beginning at 9:00 a.m.

#### Members Present:

Robert L. VanHorne, Ph.D. — Chairman  
Martha Herlevi, Vice-chairman  
Senator Larry Fasbender  
Lt. Gerald Hall  
Kay Hanrahan  
Peggy Skelton

#### Members Absent:

Joseph Plunage  
Sherry Pettit

#### Staff:

Mike Murray  
Alice Berg  
George Swartz

Ken Anderson, RADRDS, Region I  
Ron Hjelmstad, RADRDS, Region V

#### Visitors:

Newell Anderson, Department of Community Affairs  
Gordon Bollinger, Public Service Commissioner  
Judy Carlson, Special Assistant to the Governor  
Dennis Chandler, CPA, Gallusha, Higgins & Gallusha  
Tom Coghlan, Board of Directors, Valley Industrial Park  
Frank Hall, Director, St John's Alcohol Treatment Unit, St. Paul, Minn.  
W. L. Bill Holter, interested citizen  
Kyle Hopstad, Administrator, Deaconess Hospital, Glasgow  
O. E. Markle, President, Valley Industrial Park  
George Nicholas, interested citizen  
Clark Pyfer, Gallusha, Higgins & Gallusha  
Joe Reber, interested citizen

Doug Atkinson, Administrator Holy Rosary Hospital, Miles City  
Jeannine Enright, Holy Rosary Hospital  
Senator Wm. L. Mather, District 26

The meeting was called to order by Dr. VanHorne. Lt. Hall made the motion that the minutes of the last meeting be approved as read. Miss Herlevi called for the correction that she be referred to as "Miss" in place of "Mrs." The minutes were approved as corrected.

Dr. VanHorn called for an introduction of the visitors. They were introduced as appear above. Kyle Hopstad began the presentation for the Deaconess Hospital/Valley Industrial Park by showing slides and a schematic drawing of the facility. The program would consist of a 30-day residence program with family participation.

Senator Fasbender questioned the feasibility of financing such a facility. This was discussed. Mr. Hopstad introduced Mr. Frank Hall, Director of the chemical dependency unit at St. John's Hospital in St. Paul, Minnesota.

Mr. Hall described the program as it operates at St. John's and which would be the model for the VIP facility. He explained the program emphasizes family involvement as they have found this a very essential facet of treatment for the alcoholic. He pointed out that many times the alcoholic can be "cured" but when sent back to the same environment his problem still exists. By involving the family they have greatly increased the success rate for their clients. St. John's is a chemical dependency treatment facility as many clients are poly-drug abusers. The program believes abstinence is the ultimate goal; no attempt is made to teach controlled or social drinking.

The average age of clients is 25+. He stated prior to working with the Glasgow/VIP program, he researched the records and found the average age of clients from the State of Montana was in the mid 50's. He felt the State had a great number of younger abusers who were not getting treatment. This need would be more readily met if facilities closer to Montanan's than St. John's were available. He further stated the residents from Montana were in chronic stages when treatment is sought so far from home and early intervention is part of the key to success for a program. He stressed they will develop individual treatment. They have found it unreasonable to expect all clients who enter a program for treatment on a particular day have identical needs; each person must be dealt with as an individual. He stated the program would begin with a 30-day program but would not be limited to that. If other forms of treatment are indicated they would be utilized or developed.

Under the concept used at St. John's, alcoholism is considered a disease. He further stated the staff is ready to begin work at the VIP facility, a director has been selected who has trained under him at St. John's and is willing to take the job at Glasgow.

Mrs. Hanrahan posed a question regarding the family involvement and Mr. Hall responded it is not a requirement for admission but is handled in such a manner that it is rarely not a part of the treatment. AA supports the program and is utilized. A discussion was held regarding the proposed director for the program as well as the program itself.

Mr. Hall stated St. John's uses the following phases of treatment: (1) detox; (2) intermediate care including the family; (3) treatment plan developed which includes date of discharge and plans for follow-up treatment for the client for his return to his family/community. He stated the proposed director has recently completed and received Joint Commission on Accreditation of Hospitals (JCAH) for a two year period for the facility he is currently with. Montana has much to gain by beginning at this point in time as it is

able to take advantage of the other programs' trials and errors and utilize the successful parts and avoid the errors. The 30-bed proposal, he felt, was very inadequate for the needs of the State and area to be served.

Mr. Murray questioned several areas contained in the proposal, namely, the detox agreement between Deaconess Hospital/VIP; the requirements contained in the State law regarding a physical exam and the anticipated expenditure for this; and, whether Montana residents would have preference for employment in the program. Senator Fasbender questioned the success rate of 65% St. John's claims. This was discussed with Mr. Hall making the statement that 65% was the rate after the second time through treatment; 80% is the rate for persons who have gone through the program three times. These statistics include family involvement; without this involvement the rate is less than 50%. Mr. Murray's questions were addressed: current plans are to do the detox at the Deaconess Hospital in Glasgow and transport the clients to the VIP facility; State law will be complied with; to the greatest extent possible Montana residents will have precedence. However, Mr. Hall stated that should implementation of the proposed program suffer, the program would come first. Implementation of the program in toto is the goal. An extensive educational/training program is expected to be initiated for staff, which should eliminate this as a problem.

Dr. VanHorne questioned if the employee assistance type of involvement had been explored and was assured it had.

Mr. Murray asked when the program would be ready to accept clients should a contract be signed on November 8. Mr. Hopstad stated they would be in operation January 1, 1978.

Senator Fasbender again questioned the costs involved and the accuracy of the figures contained in the proposal. Mr. Hall responded that the program operated at St. John's is solvent. They run a 64-bed facility with a waiting list; 40 clients are treated on an out-patient basis; 19-20 families a week are involved in the program. There are 200-250 clients on follow-up treatment at any given time. This was discussed. Mrs. Hanrahan questioned the emphasis on detox, is it required to the extent proposed? The point was made that it may not be necessary in all instances, and if it is not used extensively, program costs would be reduced. Mr. Hall said anti-buse is not used as a treatment. He stated he would remain in an advisory capacity to the program as an ex-officio member of the board thus giving the program the advantage of his expertise in the field.

Dennis Chandler was called on at this point to expand on the fiscal areas of the proposal. He stated he is an auditor for several hospitals in the area and has utilized this information to develop the cost proposals. Contracts for physical exams were discussed as well as various other possibilities. He stressed there were apt to be areas where the anticipated costs may be off, but to the best of their ability under the circumstances, he felt the estimates were as accurate as it was possible to make them. He stated they expected to draw clients from an area larger than eastern Montana with the possibility of Canadian clients as well.

The possibilities of developing an endowment plan was discussed and it was felt that any funds which may be generated should be earmarked for the alcoholism facility for improvements to the program. The program representatives stated it would be up to the board to establish policies of this type. This led to a discussion on the feasibility of the program to become self-sufficient in the four years as the Council placed as a requirement. It was felt this was not feasible unless third party payments were developed.

Mr. Murray called on O. E. Markle to discuss the lease agreement VIP has with the Air Force for the base. He questioned the possibility Native Americans may claim the facility. Mr. Markle gave the background of VIP and the decision to take over the operation with the desire that it would become a facility Valley County would administer at a point in time. He stated the heating system will be converted, there are federal funds available for this. Montana Power Company and Montana Dakota Utilities are interested in doing some experimental work in solar heating at the facility. Currently, the contract is valid through June 30, 1978, with a guarantee of an additional year. The corporation has the support of the Under-Secretary of the Air Force, Mr. Joe Meiss, as well as a number of other persons. He felt comfortable with the agreement they have with the government and felt that if programs with merit were developed and were in operation on the base, there would be no problem with continued leasing and eventual turn-over to the County.

Mr. Hopstad stated they felt the program must have an assurance from the Council on the approximately \$400,000 per year obligation to get the program established on a sound financial basis. This was discussed.

The training/family program was discussed further. Mr. Murray expressed the opinion that transportation seemed to be the weak link in the proposal. Mr. Hopstad responded that he felt this was over-emphasized; people get to places for treatment when it is required if the treatment offered is good. Public transportation in the form of airlines, passenger train and bus service is established as well as a network of volunteers from AA persons and program counselors. A discussion was held on the facility, the furnishings it contains and what would be required for renovation to meet fire codes.

Dr. VanHorne expressed appreciation for the excellent presentation to the Council. The Glasgow delegation left the meeting.

Doug Atkinson, Jeannine Enright and Bill Mather entered the meeting. They were introduced. Ms. Enright gave a brief description of the proposal developed by Holy Rosary Hospital. It would be modeled after the program at Mandan, North Dakota called Heartview. She stated their proposal was based on private funding and a fee for services agreement with the State. It would be a residential program with a maximum of 15 beds. The staff would consist of a director, an alcohol counselor and a chaplain/counselor as well as nurses/aides. Supplementary services would be provided through the regular staff of Holy Rosary. Clients would be referred to programs in the area when released.

Mr. Atkinson spoke on the fiscal aspects of the program. He stated it was their intention to raise local funds to renovate the old hospital building

and current staff would do the work. It would necessitate raising \$63,000 if the hospital engineering staff does the work and \$90,000 if it is contracted.

Mr. Mather spoke on the community's desire to have such a program established and the cooperation that could be expected.

Dr. VanHorne questioned the need for two separate programs in eastern Montana and with the response by Mr. Atkinson that he felt the need was justified. The feasibility of the fiscal aspects of the proposal were discussed and Mr. Atkinson stated they anticipated a 90% occupancy for the 15 bed proposal. Third party payments were discussed as well as other financial aspects. Transportation was discussed with the point made by Mr. Atkinson that a system is working developed by volunteers, multiple solutions to that problem could or have been addressed.

Senator Fasbender questioned the programs anticipated bad debt figure contained in the proposal. Mr. Atkinson stated the estimate was 3.5% to 5%. This is in line with their current rate and they felt the program would fall in line. The program would reserve the right to refuse admission to clients who it was felt were not interested in rehabilitation, thus, the "revolving door" concept would be eliminated. Mr. Atkinson responded the employed and un-employed as well as Indian clients would be served. They did not expect Court commitments. An estimate of \$2,000 for a 30-day treatment module was anticipated.

Dr. VanHorne stated it appeared the program would not be ready to accept clients prior to the end of the fiscal year and thus would pose no threat to the proposal by VIP. Mr. Murray questioned the amount of funds that may be required for the program and Mr. Atkinson responded there was no way at this point to give an estimation. The possibility of an alcoholism facility at the Veteran's Hospital in Miles City was questioned. Mr. Atkinson stated the VA policy was not to duplicate services currently available in the community. If such a program was put in operation in the hospital, it would only treat veterans; the community would still have an obligation to supply services to others in need.

Mrs. Hanrahan questioned the statement "only patients willing to be rehabilitated will be admitted" contained in the proposal. This was discussed with the point made fee for services would cover a portion of this element unable to pay, but the program would reserve the right to refuse treatment. Mr. Atkinson made the point their program had the support of the medical professionals in the area.

Dr. VanHorne called for the question. The Miles City people were thanked for the informative session with the Council and was advised further contact would be made with them. The Council anticipated some funding for the program when it was established. Mr. Murray stated he would be available to meet with Ms Enright and Mr. Atkinson to discuss any matters they wished. Mr. Murray made the point that the "Department of Institutions personnel" referred to in the proposal was not speaking for the Department when he visited the program, he was acting on his own, in fact, exploring the possibility of becoming an employee of the program. Ms. Enright stated the correction would be noted.

The Miles City delegation left the meeting at this point.

After a lunch break the meeting re-convened with Mr. Ken Anderson and Mr. Clint Grimes in attendance.

Mr. Grimes gave his input by stating both programs appeared to be workable, however, they were expensive. He posed the possibility of the Council considering entering into a fee for services agreement or contract with programs rather than fund a particular program. This was discussed; it did not appear feasible to expect a program to become operational without assistance from the State, it was unreasonable to expect this. Mr. Grimes stated he felt the medical services (detox) was grossly over-estimated, extensive detox and medical services are not required in many instances.

The possibility of the VIP program becoming operational with a 15-bed start-up factor, two counselors and a director was discussed. The funding for Galen was discussed. Mr. Grimes stated that in his opinion JCAH accreditation only made programs more expensive - high costs do not necessarily indicate an effective program. Insurance was discussed. This led to a discussion of CompCare, a program in operation in Butte in an established hospital where they take advantage of insurance coverage for payment of treatment.

Mrs. Hanrahan posed the question if a program can start up and then utilize a fee for services basis for funding. It was agreed that this may be a possibility, and the program receiving the Certificate of Need will be evaluated after a 6 month period and future funding would be dependent upon the results of the evaluation.

Dr. VanHorne stated it appeared Miles City could not have a program operational in FY'78. The potential number of clients was discussed with an agreement that there was an apparent need for more than 30 beds in eastern Montana. Mr. Grimes left the meeting.

The next item of business was a proposal by CompCare for an advertising campaign for the State. Copies were distributed to the members and the recommendation made that it be tabled until the next meeting. The advertisement in the Montana Citizen, a State Chamber of Commerce publication was examined. It was agreed that for the persons reached by this publication, it was good, but should it be used elsewhere, the inclusion of the female should be developed. The possibility of posters or sending the ad to various State agencies was a possibility to be investigated. It was estimated the magazine reached approximately 30,000 businessmen in the State.

The Women's Task Force meeting held the day prior to the Council meeting was discussed. Women Council members were present and plans developed for: (1) goals and objectives of the Task Force; (2) establish Regional task forces, i.e., a public relations person in each of the five Mental Health Regions of the State (this would involve 10 women, 1 delegate and 1 alternate); (3) duties for the regional people; (4) ancillary persons - physicians, psychologists, pharmacologists, etc.; (5) the aim would be to reach the middle aged, middle income woman substance abuser. It was agreed the Council would not require minutes of the Task Force, but would like occasional reports on progress made.



A report was given on the site visit to Washington House October 10. Mr. Murray, Mrs. Hanrahan, Ken Anderson and Harold Schutt, director of a Kalispell program, made the trip. The facility had a 4-5 day detox stay with referral at that time to another facility, such as a half-way house. There was family contact and contact with the employer. The majority of clients were on an out-patient basis - 400-450 per month. The facility was primarily detox only, not a comprehensive treatment program; charges were assessed for services rendered (10% paid for treatment when recieved, 90% at a later date). DWI clients were included in the program. Referrals/contracts/courts were the major sources of clients. It appeared the module was not feasible for the State of Montana except maybe Great Falls under some circumstances.

The grant application revision for Region III - Rimrock was not received. It was expected they would be submitted on a date set October 17 as Mr. Swartz was to attend a Board meeting for Rimrock at that time. Miss Herlevi made the motion that action on the Rimrock grant applications be deferred until the next meeting after Mr. Swartz' visit. Second by Gary Hall; motion carried.

The employee assistance program currently in operation through the Division was discussed. It was the desire of the Council that the availability of this services be "advertised" to make more agencies aware of the program.

A proposal from the Blackfeet Reservation program to renovate the lavatory facilities was discussed. They have asked for \$10,000 from the State and IHS will match that amount. Mr. Hall made the motion to fund this proposal; second by Mrs. Hanrahan. Motion carried.

The Missoula Indian Alcohol and Drug Program was discussed. Mr. Murray stated they will receive State approval and funding but additional funds are necessary to increase salaries. The director of the program has an M.S.W. and a counselor a Master's. The program is very high quality but personnel have job offers at an increase and it is felt State funding in the amount of \$10,500 would allow them to remain. Senator Fasbender stated you cannot always equate salaries and quality treatment. Mrs. Skelton made the motion to fund the program for the sum of \$10,500; second by Mrs. Hanrahan. Motion carried.

RADRDs were the next item of business. Formula grant funds are available for these positions. However, of the five Regions, only four were active the past year and of those four, two (Regions I and V) remain. A proposal to increase the area of responsibility for the two existing and the Division serving the mid-section of the State was discussed. The possibility of having these positions become State employees was discussed. Mr. Hjelstad said he felt a higher quality of service was delivered under the current arrangement and he would prefer to remain as is. Mr. Anderson discussed his proposal for funding and expressed a desire to retain the services of a full-time secretary. He felt she was an exceptionally good staff member who had a good deal of experience in the area, was well-received and the program would suffer should she go elsewhere. Discussion. Mr. Hall made the motion that Mr. Anderson's program (Region V) be funded \$45,000 and include the full-time secretary. Second by Miss Herlevi; motion carried. Following

## MINUTES

### MONTANA ADVISORY COUNCIL ON ALCOHOL & DRUG DEPENDENCY

The State Advisory Council on Alcohol & Drug Dependency met in the hospital, Valley Industrial Park, Glasgow Air Force Base, MT on November 8, 1977 beginning at 1:00 p.m.

#### MEMBERS PRESENT:

Robert L. VanHorne, Ph.D., Chairman  
Martha Herlevi, Vice-Chairman  
Lt. Gary Hall  
Katherine Hanrahan  
Joseph Plumage  
Peggy Skelton

#### MEMBERS ABSENT:

Senator Larry Fasbender  
Shari Pettit

#### STAFF:

Mike Murray  
Alice Berg  
Rod Gwaltney  
George Swartz

Ken Anderson, Region V RADRDS  
Ron Hjelmstad, Region I RADRDS

#### VISITORS: (CompCare Corporation)

Allen Herkimer, Jr.  
John Brazill, Ed.D.

#### PROGRAM PERSONNEL:

Dick Baumberger, Providence Alcoholism Center, Great Falls  
Jim Brown, Jim Seykora, Jeff Hill, Dan Gebhardt, M.D., Big Horn County  
Bob MacConnell, Treasure/Rosebud County Alcohol Program  
Jack Pipe, Lewellyn Cantrell, Billings American Indian Alliance  
Dick King, Blane Hoyt, District 4 Human Resources Development Council

#### VIP/FRANCES MAHON DEACONESS HOSPITAL REPRESENTATIVES:

Jim Horne, President, VIP  
C. H. Brocksmith, Chairman, Board of Directors, Hospital  
Kelly Caldwell, KUMV-TV, Williston, N.D.  
Kyle Hopstad, Administrator, Frances Mahon Deaconess Hospital

Kitty Lou Langen, Board of Directors, Hospital  
Linda Madsen, KLTZ, Glasgow  
O. E. Markle, VIP Past President  
George Nicholas, interested citizen

The Council was welcomed to the Valley Industrial Park by Mr. Jim Horne and was introduced to persons in attendance. Dr. VanHorne expressed the Council's appreciation for the invitation to meet at the facility. At this point the Council members, staff and visitors toured the surrounding area and the facility. After the break for lunch Mr. Kyle Hopstad spoke on the current status of program implementation. Mr. Murray presented the Approval Certificate to Mr. C. H. Brocksmith, Chairman of the Board of Trustees, Frances Mahon Deaconess Hospital.

The Council convened at 1:00 p.m. in the Board room at the hospital with the program people, staff and Council members in attendance. A motion to approve the minutes of the last meeting and commend the secretary for a job well done was made by Miss Herlevi, motion seconded, carried.

Mr. Murray introduced Mr. Allen Herkimer, Jr. and Mr. John Brazill from Comp-Care Corporation, Newport Beach, California. They discussed the proposal presented at the last Council meeting for a State-wide advertising campaign dealing with alcoholism prevention and treatment. Mr. Brazill spoke on the type of program which would be done in the State of Montana. It was anticipated the Division and program people would be involved in development of a campaign which would cover radio, TV schools, etc. All materials developed would become the property of the State.

Mr. Herkimer spoke on the phases of the proposal and stated it would not be compulsory to do all phases should some not be pertinent or necessary.

Mr. Brazill said alcoholism in the concept of their proposal was treated under the general health care umbrella. He explained they were a private contract agency under the Care Unit Division of their Corporation. He gave the statistics that 1 out of 40 automobile drivers at any given time is under the influence of alcohol; one-half of the murders committed in the country involve alcohol. He stated he has heard the number 9,000,000 alcoholics in the U.S. for the past 10 years or so, he expected it was more than that if 8% of the population is alcoholic. In the Los Angeles area where he lives, there are two pre-teen AA groups. There appears to be a 2/1 male/female ratio, but he stated he expected those statistics may not be accurate as it has only been in the past few years that the woman alcoholic has come to the attention of the public. It was comparatively easy in the past for a woman to be an alcoholic for years but never come to the attention of anyone but her immediate family as they were not in the public eye.

The objective of the campaign would be to create public awareness of the disease of alcoholism. They would assist the Division, Mr. Herkimer, Mr. Brazill and Susan Lau to be the participants in the campaign planning. The object would be to make the "team" self-sufficient. The Corporation is in-

volved to a great extent in advertising and promotion, as well as the operation of hospitals. They have just contracted for the development and operation of two hospitals in Great Britain.

Mr. Herkimer spoke on the phases of the proposal and stated the time lines developed would have the project completed in a 5 month period. The project would cost \$19,600-24,400 plus travel and per diem. It would not be necessary to purchase all phases of the proposal if it was deemed some were not pertinent. It was not mandatory that phases be completed in the order presented. Each was an entity not dependent upon the others.

As much of the work as possible will be done in the "shop." He emphasized the objective was Timeliness, Theme, and Teamwork to make the project a success.

Mr. Herkimer thanked the Council for allowing him and Mr. Brazill to attend the meeting and present their proposal for discussion.

Mr. George Swartz spoke on the Urban Indian Proposals submitted as a result of the advertising the availability of funds for such a program. He stated 5 programs had submitted proposals - Big Horn County, Hardin; District 4 Human Resources Development Council, Havre; Billings American Indian Alliance; Missoula Indian Alcohol & Drug Abuse Program and the Butte Indian Alliance.

He called on Mr. Jim Brown, Region III Mental Health Center, Hardin, Jim Seykora, County Attorney, and Dr. Ben Gebhardt, Indian Health Services Hospital, to present their proposal.

Mr. Brown gave Mr. Swartz six letters of support to be included in the proposal. He then began by stating Big Horn County does not have the services of an alcohol program. Currently what treatment being given is done through the mental health office but alcoholism treatment is not compatible with the mental health philosophy and leaves much to be desired. Their proposal was for a fundamental program that would cooperate with the Crow. Currently, tribal politics make it impossible to operate a program on the reservation. Funds for transportation to detox at ARC in Billings were included; some research on modalities that are effective in the treatment of Indians would be done; clients would be screened; administration and support services would be given by South Central Regional Mental Health; DWI schools would be operated. The program would serve both the white and Indian population but would more directly benefit the Indian population in Hardin and the surrounding area. Mrs. Hanrahan questioned an item on page 3 - response: \$400 training, \$3,700 travel. Mr. Plumage questioned the detox phase. Mr. Brown stated there were problems regarding jurisdiction, but exploration to surmount this problem would be undertaken.

Mr. Seykora, County Attorney for Big Horn County, stated, "Hardin does not have a problem." He stated in 1975 there were 72 DWI arrests in the County; 1976 - 79; 1977 - 9 month period, 51. Alcohol related offenses: 1975 - 387; 1976 - 394; 1977 - 9 month period, 476. According to the coronor's report in the past three months 21 deaths have occurred, 45% directly related to alcohol. Three typical cases chosen show 1 person had been arrested 176 times; a second 143 and a third had 135 arrests. Mr. Plumage questioned if they were all alcohol related. Mr. Seykora responded, yes. From his brief-

case he took an assortment of bottles and cans ranging from wine to Mennen Aftershave to hair spray and Lysol Disinfectant Spray to a plastic bag full of copper spray paint. He stated all of these had been picked up in a two block area from his office to the airport and represented the type of "drink" common to Hardin. He stated in his belief they did not have a problem in Hardin, they had a disaster. He hoped this disaster would be overcome with a program which would be available to the people.

Dr. Gebhardt spoke of stopping near the airport to help a person who was lying near a building only to discover the person was dead. He stated alcohol and alcohol related problems were the area of greatest need in the Hardin area.

Mrs. Hanrahan questioned if the counselor(s) for the proposed program would be Indian and if the Indians would be involved with the program. Mr. Jeff Hill stated yes, they anticipated both a man and a woman Indian counselor for the program. Mrs. Skelton questioned Mr. Hill's current involvement with the reservation and if the detox facility there was still in operation. Mr. Hill responded that the detox facility was closed at this point and would not re-open until a court decision involving tribal affairs was made. Mr. Brown stated the Indian Health Services Hospital was available for detox and would be utilized. There would be no duplication of services. Mrs. Hanrahan asked if the program people were aware that DWA funding was from another source. They answered in the affirmative.

Dr. VanHorne questioned the source of funds the Council was to award with Mr. Swartz responding they were federal funds which would be received on a yearly basis and would continue to be available depending upon Council priority. Big Horn County will give the program their alcohol tax funds and the project has an additional small sum available.

A discussion was held regarding the problems facing the community/area with the development of the coal in the Decker area. Decker currently consists of 40 "very brave souls" with no sewer or water but within a two or three year period it is expected there will be an influx of as many as 20,000 persons to the town. Historically the Crow Reservation has been dry and this adds to the problem in Hardin - everyone goes there to drink. Further discussion on the extent of drug or inhalent abuse in the area. It was pointed out no other problem reaches the magnitude of the alcohol problem. Mrs. Hanrahan commended the gentlemen from Hardin for taking the time and putting forth the effort to attend this meeting and present their proposal. A final point was made that their proposal was for \$30,000.

Lewellyn "Rusty" Cantrell spoke very ably for the Billings American Indian Alliance proposal. It would develop AA groups which would be effective for the Indian population. As AA exists now, the Indians attend a few meetings but by nature are shy and reluctant to participate and thus drop out. He stated both facilities currently utilized by their program for detox or residential treatment (Galen and Rimrock) are AA oriented and this leaves the Indian population with no effective follow-up when they are released. Mr. Pike, Project Director, spoke on a survey made in the Billings area showing 43 tribes of Indians residing in the Billings area from 23 reservations. He stated employment was a problem for the Indian population.

He pointed out it was very disappointing to have a client complete the program at Galen or Rimrock, be released to nearly nothing. Their proposal would develop something for them to be released to for continued progress, not just an eventual return to Galen or Rimrock. Mr. Murray questioned if the program planned to secure or apply for funds from Yellowstone County. They stated yes. A discussion was held on the problems relating to the Indian/white people. Mr. MacConnell questioned the lack of Indian involvement with AA.

The Council thanked Mr. Cantrell and Mr. Pipe for taking time to be present.

Mr. Dick King and Mr. Blane Hoyt explained their proposal at this time. It also dealt with the Indian reluctance/inability to be effective AA members. They also would develop a manual and guidelines which would be for the Indian population. Mr. King stated the Indian population who go through the treatment program at Hill-Top have a 5% recovery rate compared with 30% for Anglos; 33% of the clients at Hill-Top are Indian. Their proposal would not duplicate existing programs, but would expand on them, make them effective for the Indian population. Alcohol is the common denominator for Indian people state-wide. Their program would be available to anyone wishing to utilize it; it would be developed by two people during the grant period and funding in additional years would not be necessary.

Mr. Blane Hoyt gave some background on the District 4 Human Resources Development Council and their current expertise in administering programs. They anticipate cooperation with the four nearby reservations to develop their proposal. Mrs. Hanrahan questioned the AA philosophy regarding funds and monetary matters and if considering this AA concept, it was possible to develop the proposal. Mr. Hoyt explained the "handbook" to be developed would demonstrate the differences in the races and the family counseling aspect. The Council thanked Messers Hoyt and King for taking the time to come to the meeting and present the proposal.

Mr. Swartz explained the other two proposals: Butte Indian Alliance "A New Life" which would utilize the Indian culture as a path for rehabilitation and the Missoula Indian Alcohol and Drug Program for funding a half-way house. Mrs. Skelton had discussed this proposal with Mr. Jones, Director. There was minor discussion regarding these two proposals.

Mr. Plumage volunteered to chair a committee to review the 5 proposals submitted and make a recommendation to the next Council meeting. Dr. VanHorne appointed Mrs. Skelton and Mrs. Hanrahan to serve with Mr. Plumage and make a recommendation to the December Council meeting.

Mr. Rod Gwaltney, Leader, Prevention & Education Section, reported on the mini-grants received after advertising the availability of funds. Twenty-four have been received. Dr. VanHorne appointed Miss Herlevi and Mr. Hall and volunteered himself to a committee to review these applications and report to the next Council meeting.

Mr. Gwaltney requested the Women's Task Force cancel the planned December meeting and hold it in January. This was agreeable to the women council members who are members of the Task Force. Mrs. Skelton gave the secretary a packet of information on the Task Force and Mrs. Hanrahan stated she has some information which she would send to the office. Mr. Dick Baumberger questioned if program people would become involved with the Task Force. He was assured they would.

Mr. Gwaltney reported on the Rimrock application. Division staff reviewing the applications were Dick Petaja, Darryl Bruno and himself. Standard forms and the format used by every other program in the State again were not followed by Rimrock. Goals and objectives were measureable; however, budgets did not include detail or justification. In the case of Morningstar section, goals and objectives were not included. The total application is for \$300,000 and Morningstar is included in that amount for approximately \$200,000. Miss Herlevi asked if Mr. Swartz had attended the Rimrock Board meeting as stated at the last Council meeting. This was discussed. Rimrock was requested to separate the budgets by county and their program and be consistent with the format required by the State.

Mr. Murray discussed the current problems with funding in Region III and a meeting in Harlowton he and Mr. Swartz attended. He stated rural county residents are mad and frustrated over the hassle to receive funding. In Mr. Murray's opinion, these residents have justification to be upset; however, he stated blame for funding should be a shared responsibility rather than the sole responsibility of the Division and Advisory Council. He questioned why every other program in the State - one man programs to large multi-staff agencies could submit budgets including detail and justification, measurable goals and objectives - with the exception of Rimrock who consistently uses their own format with only summary budgets and no justification. He requested Council approval to develop, negotiate and fund immediately, proposals for each of the rural areas Rimrock is providing services to.

Miss Herlevi reported on a meeting she attended along with Mr. Murray and Mr. Swartz and the counties involved. She stated they handled themselves very honorably under very bad circumstances. Miss Herlevi made a motion that the Division be allowed to negotiate and sign contracts to start alcohol services in each of the rural areas served by Rimrock prior to the next Council meeting; that the Morningstar component of the application be submitted to each reservation alcohol program, tribal chairman and approved urban Indian alcohol program for review and comment and Rimrock be requested to submit a detailed budget with justification for central office operation. Further, that Dr. Simmons be invited to present his application to the next Advisory Council meeting. Second by Mr. Plumage; motion carried.

Mr. Baumberger requested the opportunity to present a request to the Council from Providence Alcoholism Center which involves some repairs and expenditures for his facility in the amount of \$14,138.55. Mr. Hall made a motion that if the funds are available the Providence request be granted. Second by Mr. Plumage; motion carried.

Mr. Murray informed the Council and persons present that Mr. Ken Anderson had recently been awarded \$20,000 to study women's and youth's needs. Miss Herlevi made a motion to commend Mr. Anderson on his accomplishment; second by Mrs. Hanrahan. Motion carried.

Mr. Murray gave a report on the current status of the Division budget. The Northern Cheyenne Tribe had been awarded \$26,000 in the event they became an approved program; it appears these funds will be available for another purpose at this point.

Dr. VanHorne asked if it would be possible for Mrs. Hanrahan to attend a meeting in Billings with Rimrock. Mrs. Hanrahan agreed and asked the secretary to look up the number of contacts, etc. with Rimrock and give her the information prior to the meeting November 16.

Mr. Pollari, Director, Glendive Alcohol Satellite, stated he did not feel an exception should be made for Rimrock. All programs had standards to meet to receive approval and funding and the same rules should apply to all. It was the consensus of opinion of the Council that the secretary draft a letter to be signed by Dr. VanHorne expressing the Council's feelings as to this matter.

The date for the next Council meeting was set for December 7 & 8 in Helena.

Mrs. Hanrahan requested a status report on the renovation costs, etc., for the VIP facility. She also asked that the CompCare proposal be developed so the Council would be aware of the total costs involved. She further felt a figure currently spent would be useful as well as a comparison figure from other agency's budgets. Mr. Murray stated the figure submitted in the grant application by Deaconess Hospital was \$79,439, but it was expected this would be reduced a considerable amount. The budget as submitted was reviewed with the Council in agreement that several areas such as carpeting, decorating could be eliminated at this point. The current application is for a period of Novmber 9 through December 31, 1977. Salaries for the hospital administrator, as well as the housekeeper, maintenance man were discussed.

Dr. VanHorne stated it was the consensus of the Council that Mr. Murray be authorized to make the necessary adjustments in the budget submitted prior to signing the contract.

Mrs. Skelton made a motion to adjourn; second by Mr. Plumage. Motion carried.

Respectfully submitted,

  
ALICE BERG

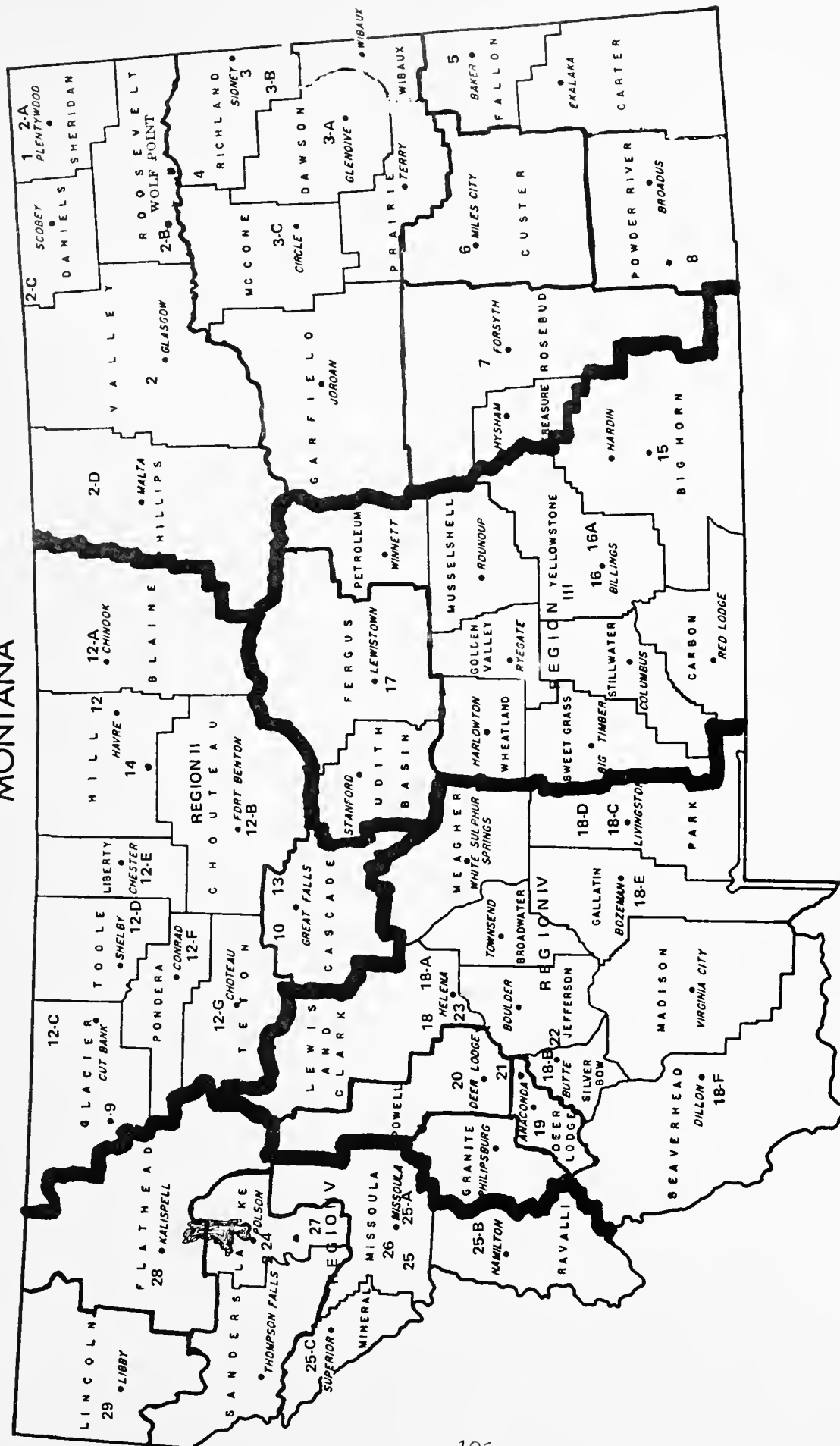


## SECTION 4

MAP AND KEY: STATEWIDE ALCOHOL PROGRAM SERVICE AREA  
LISTING OF ALCOHOLISM SERVICE PROVIDERS AND SERVICE  
PROVIDED  
ALCOHOL CLIENT INTAKES (ADMISSIONS) BY PROGRAM



# MONTANA



No. 1052 — County Outline Map  
STATE PUBLISHING COMPANY  
Helena



## ALCOHOL PROGRAMS MAP KEY

### Region I

1. RADRDS - Plentywood
2. High Plains Council for District I
  - 2-A Sheridan County
  - 2-B Roosevelt County
  - 2-C Daniels County
  - 2-D Phillips County
3. District II Public Alcoholism Program
  - 3-A Glendive Alcohol Satellite
  - 3-B Sidney Alcohol Satellite
  - 3-C Circle Alcohol Satellite
4. Fort Peck Tribal Alcoholism Program
5. Tri-County Alcoholism Program
6. Custer County Alcohol Program
7. Rosebud County Alcohol Program
8. Northern Cheyenne Reservation Alcohol Program

### Region II

9. Blackfeet Tribal Alcohol Program
10. Cascade County Alcohol Program
11. Fort Belknap Tribal Alcohol Program
12. Hill-Top Recovery Center
  - 12-A Chinook Outreach
  - 12-B Fort Benton Outreach
  - 12-C Cut Bank Outreach
  - 12-D Shelby Outreach
  - 12-E Chester Outreach
  - 12-F Conrad Outreach
  - 12-G Choteau Outreach
13. Providence Resocialization Center
14. Rocky Boy Tribal Alcohol Program

### Region III

15. Crow Reservation Alcohol Program
16. Rimrock Guidance Foundation
  - 16-A Alcoholism Receiving Center
17. Fergus County Alcohol Program

#### Region IV

18. Alcohol Rehabilitation Association of Western Montana
  - 18-A Helena Alcohol Services
  - 18-B Butte Alcohol Services
  - 18-C Park Alcohol Services
  - 18-D Steppingstone Alcohol Services
  - 18-E Bozeman Problem Drinking Center
  - 18-F Dillon Alcohol Services
19. Deer Lodge County Alcohol Program
20. Powell County Alcohol Center
21. Galen State Hospital
22. North American Indian Alliance Alcohol Services
23. Boyd's Guest House

#### Region V

24. RADRDS
25. Alcohol Action
  - 25-A Missoula Center
  - 25-B Hamilton Center
  - 25-C Superior Center
26. Missoula Indian Alcohol and Drug
27. Flathead Alcoholism and Drug Abuse Center
28. Alcohol Service Center (Kalispell)
29. Alcohol Service Center (Lincoln County)

ALCOHOL PROGRAMS IN REGION I

1. CARTER, FALLON, POWDER RIVER ALCOHOL PROGRAM      DIRECTOR: Doug Austin  
10 W. Fallon Street  
Baker, Montana 59313

Services Provided: Outpatient, information and referral, community education.

2. CUSTER COUNTY ALCOHOL PROGRAM      DIRECTOR: Jim Irvin  
Custer County Courthouse      PHONE: 232-6542  
Miles City, Montana 59301

Services Provided: Outpatient, information & referral, community education.

3. DISTRICT II PUBLIC ALCOHOLISM PROGRAM      DIRECTOR: Ron Hjelmsted  
Plentywood, Montana 59254      PHONE: 765-2530

Services Provided: Outpatient, information & referral, community education  
for four (4) counties.

SATELLITES:

GLENDIVE ALCOHOL SATELLITE  
P.O. Box 281  
Glendive, Montana 59330

COUNSELOR: Jack Pollari  
PHONE: 365-5942

SIDNEY ALCOHOL SATELLITE  
P.O. Box 868  
Sidney, Montana 59270

COUNSELOR: John Brekke  
PHONE: 482-2207

CIRCLE ALCOHOL SATELLITE  
c/o McCone County Courthouse  
Circle, Montana 59215

COUNSELOR: Vacant  
PHONE: 458-2380

4. FORT PECK TRIBAL ALCOHOLISM PROGRAM  
P.O. Box 307  
Glasgow, Montana 59230

DIRECTOR: Melvin Eagleman, S  
PHONE: 768-3852

Services Provided: Outpatient, community education, information & referral.

5. HIGH PLAINS COUNCIL FOR DISTRICT I  
P.O. Box 852  
Glasgow, Montana 59230

DIRECTOR: Herb Sukut  
PHONE: 228-9093

Services Provided: Outpatient, community education, information & referral.

SATELLITES:

Sheridan County Courthouse  
Plentywood, Montana 59254

COUNSELOR: Jergen Jensen  
PHONE: 765-2361

Roosevelt County Courthouse  
P.O. Box 675  
Wolf Point, Montana 49201

COUNSELOR: Barb Taddonio  
PHONE: 653-2131

Scobey City Hall  
P.O. Box 398  
Scobey, Montana 59263

COUNSELOR: Gordy Cornwell  
PHONE: 487-5091

Phillips County  
P.O. Box 1052  
Malta, Montana 59538

COUNSELOR: Phyllis Wimmer  
PHONE: 654-2005

6. ROSEBUD COUNTY ALCOHOL PROGRAM  
P.O. Box 224  
Forsyth, Montana 59327

DIRECTOR: Harold Selvig  
PHONE: 356-2670

Services Provided: Outpatient, community education, information & referral.

7. NORTHERN CHEYENNE RESERVATION  
ALCOHOLISM PROGRAM  
P.O. Box 381  
Lame Deer, Montana 59043

DIRECTOR: Jack Bad Horse  
PHONE: 477-6381

Services Provided: Detoxification, inpatient, outpatient, drop-in,  
information & referral.

Not a State approved alcoholism program.

ALCOHOL PROGRAMS IN REGION II

- |   |   |
|---|---|
| 1. BLACKFEET TRIBAL ALCOHOLISM PROGRAM<br>P.O. Box 426<br>Browning, Montana 59417 | DIRECTOR: Margaret Kennedy<br>PHONE: 338-7178 |
|---|---|

Services Provided: Detoxification, outpatient counseling, prevention,  
rehabilitation, information & referral.

- |   |   |
|---|---|
| 2. CASCADE COUNTY ALCOHOL PROGRAM<br>1130 17th Avenue South<br>Great Falls, Montana 59401 | DIRECTOR: Jon Tovson<br>PHONE: 761-6700 |
|---|---|

Cascade County Alcoholism Coordination Authority

- |  |  |
|--|--|
| 3. FORT BELKNAP TRIBAL ALCOHOLISM PROGRAM<br>Fort Belknap Reservation<br>Harlem, Montana 59526 | DIRECTOR: Florence Cole<br>PHONE: 353-2731 |
|--|--|

Services Provided: Detoxification, intermediate care, outpatient,  
information & referral.

- |   |  |
|---|--|
| 4. HILL-TOP RECOVERY CENTER<br>1020 Assiniboine<br>Havre, Montana 59501 | DIRECTOR: George Bowery<br>PHONE: 265-9665 |
|---|--|

Services Provided: Detoxification, intermediate care, outpatient,  
outreach, prevention, information & referral.

SATELLITES

P.O. Box 1384  
Fort Benton, Montana 59442

COUNSELOR: Carol Richard  
PHONE: 622-3625

350 O'Haire Blvd.  
Shelby, Montana 59474  
Conrad, Montana  
Choteau, Montana  
Chester, Montana

COUNSELOR: Jackie Severson  
PHONE: 434-5002

Box 1017  
Chinook, Montana 59523

COUNSELOR: Mary Pyette  
PHONE: 357-4129

416 - Mt. View Blvd  
Cut Bank, Montana 59427

COUNSELOR: Laurie Frisbee  
PHONE: 873-5654



5. PROVIDENCE RESOCIALIZATION CENTER  
920 4th Avenue North  
Great Falls, Montana 59401

DIRECTOR: Dick Baumberger  
PHONE: 727-2512

Services Provided: Intermediate care, outpatient, aftercare, education,  
prevention, information & referral.

6. ROCKY BOY TRIBAL ALCOHOLISM PROGRAM  
Rocky Boy Route  
Box Elder, Montana 59521

DIRECTOR: Clifford Sutherland  
PHONE: 395-2736

Services Provided: Detoxification, halfway house, outpatient, infor-  
mation & referral.

Not a State-approved alcoholism program.

### ALCOHOL PROGRAMS IN REGION III

1. RIMROCK GUIDANCE FOUNDATION  
923 North 29th Street  
Billings, Montana 59101
- DIRECTOR: Dr. Howard S.

Services Provided: Intermediate care, detoxification in ARC, outpatient services (individual, family and group), outreach, aftercare, community education, prevention, information & referral.

Alcoholism Receiving Center  
Billings Deaconess Hospital - Combined with Rimrock  
P.O. Box 2547  
Billings, Montana 59101

Services Provided: Detoxification & outreach.

2. CROW RESERVATION ALCOHOLISM PROGRAM DIRECTOR: Ben Jefferson  
Box 28 PHONE: 638-2662  
Crow Agency, Montana 59022

Services Provided: Detoxification, outpatient, information & referral,  
community education.

3. SOUTH CENTRAL MENTAL HEALTH CENTER DIRECTOR: Bryce Huggett  
1245 N. 29th Street PHONE: 252-5658  
Billings, Montana 59101

Services Provided: Outpatient, information & referral

4. CENTRAL MONTANA FAMILY SERVICES DIRECTOR: Gordon Lindl  
Box 963 PHONE: 538-8421  
Lewistown, Montana

Services Provided: Outpatient, information & referral

ALCOHOL PROGRAMS IN REGION IV

- |    |   |  |
|----|---|--|
| 1. | ALCOHOLISM REHABILITATION ASSOCIATION<br>FOR SOUTHWESTERN MONTANA<br>801 North Last Chance Gulch<br>Helena, Montana 59601 | DIRECTOR: Jim Scott<br>PHONE: 442-0310 |
|----|---|--|

Services Provided: Detoxification, outpatient counseling, information & referral, prevention.

SATELLITES

- |   |   |
|---|---|
| Southwestern Alcoholism Services<br>510 Logan<br>Helena, Montana 59601                              | COUNSELOR: K. M. Roberts<br>PHONE: 442-8831     |
| Butte Alcohol Program<br>225 South Idaho<br>Butte, Montana 59701                                    | COUNSELOR: Marcella McGeever<br>PHONE: 792-0224 |
| Steppingstone Alcoholism Program<br>South of Livingston, Box 1264<br>Livingston, Montana 59047      | COUNSELOR: Wally Callahan<br>PHONE: 222-0795    |
| Bozeman Problem Drinking Center<br>Room 316<br>First National Bank Bldg.,<br>Bozeman, Montana 59715 | COUNSELOR: Chuck Heath<br>PHONE: 586-5493       |
| Dillon Alcohol Services<br>126 S. Montana<br>Dillon, Montana 59725                                  | COUNSELOR: Vacant<br>PHONE: 683-4305            |

- |    |   |  |
|----|---|--|
| 2. | BOYD'S GUEST HOUSE<br>410 9th Avenue<br>Helena, Montana 59601 | DIRECTOR: Boyd Andrew<br>PHONE: 443-2343 |
|----|---|--|

Services Provided: Halfway house, outpatient, intermediate, information & referral.

- |    |   |  |
|----|---|--|
| 3. | CARE UNIT<br>Silver Bow General Hospital<br>Continental Drive<br>Butte, Montana 59701 | DIRECTOR: Robert Farren<br>PHONE: 723-4341 |
|----|---|--|

Services Provided: Acute detoxification and in-residence treatment program

4. DEER LODGE COUNTY ALCOHOL PROGRAM DIRECTOR: Jim Weist  
600 Oak, Community Hospital PHONE: 563-6601  
Anaconda, Montana 59711

Services Provided: Outpatient, information & referral.

5. GALEN STATE HOSPITAL    DIRECTOR: Don Holmes  
Alcohol Treatment and Rehabilitation                      PHONE: 693-2281  
Program  
Route 1, Galen  
Deer Lodge, Montana 59722

Services Provided: Detoxification, 21 day in-resident treatment program, recidivists program, and referral for aftercare.

6. NORTH AMERICAN INDIAN ALLIANCE DIRECTOR: Ozzie Williamson  
ALCOHOL SERVICES PHONE: 723-3648  
2 East Galena  
Butte, Montana 59701

- |    |                                     |           |           |
|----|-------------------------------------|-----------|-----------|
| 7. | PARK COUNTY PROBLEM DRINKING CENTER | DIRECTOR: | Mary Long |
|    | 107 W. Callendar                    | PHONE:    | 222-2812  |
|    | Livingston, Montana 59047           |           |           |

Services Provided: Outpatient, Information & referral.

8. POWELL COUNTY ALCOHOLISM CENTER DIRECTOR: Paul Miller  
309 Missouri Avenue PHONE: 846-3442  
Deer Lodge, Montana 59722

Services Provided: Outpatient, information and referral.

ALCOHOL PROGRAMS IN REGION V

1. ALCOHOL SERVICE CENTER OF LINCOLN COUNTY, INC.  
P.O. Box 756  
Libby, Montana 59923
- DIRECTOR: Royce Gilbertson  
PHONE: 293-7731

Services Provided: Outpatient, prevention & information & referral.

2. FLATHEAD ALCOHOLISM AND DRUG ABUSE INFORMATION CENTER  
P.O. Box 270  
Ronan, Montana
- DIRECTOR: Harold "Sarge" Campbell  
PHONE: 676-0596

Services Provided: Detoxification, intermediate care, outpatient, outreach, follow-up, prevention & education, information & referral.

3. ALCOHOL SERVICE CENTER  
944 South Main  
Kalispell, Montana 59901
- DIRECTOR: Harold Schutt  
PHONE: 755-6453

Services Provided: Outpatient, prevention, education, outreach, information & referral, detoxification.

4. ALCOHOL ACTION/WESTERN MONTANA REGIONAL ALCOHOLISM SERVICES, INC.  
612 South Higgins  
Missoula, Montana 59801
- DIRECTOR: Marie Morton  
PHONE: 728-7712

Services Provided: Outpatient, outreach, community education, information & referral.

SATELLITES

ALCOHOL ACTION  
Box 1121  
Hamilton, Montana 59840

COUNSELOR: Vic Evered  
PHONE: 363-3060

ALCOHOL ACTION  
c/o County Welfare Office  
Superior, Montana 59872

PHONE: 728-7712 (Missoula) or  
County Welfare

5. MISSOULA GENERAL HOSPITAL  
300 N. 2nd Street  
Missoula, Montana 59801

DIRECTOR: J.P. Smith  
PHONE: 542-2191

Services Provided: Detoxification, Intermediate care

6.   MISSOULA INDIAN ALCOHOL AND DRUG                   DIRECTOR:       Tom Jones  
      401 Railroad West                               PHONE:         721-2700  
      Missoula, Montana 59801

Services Provided: Outpatient, information & referral.

7.   SANDERS COUNTY CHEMICAL DEPENDENCY               DIRECTOR:       Frank Humble  
      Box 940   PHONE:         827-4241  
      Thompson Falls, Montana 59873

Services Provided: Outpatient, information & referral.

In June, 1976, the Addictive Diseases Bureau received a grant from the Council of State and Territorial Alcoholism Authorities to develop an Alcohol Management Information System. This system is now in place and developed to the point that we can accurately report and verify the following figures for Fiscal Year 1977.

CLIENT INTAKES (Admissions)			
	<u>Calendar Year</u>		<u>F.Y.</u>
	<u>1975</u>	<u>1976</u>	<u>1977</u>
<u>Region I</u>			
Colstrip Youth Project		32	111
Custer County Alcohol	194	32	43
District II	313	236	279
District I	268	248	244
***Northern Cheyenne	---	394	287
Rosebud County Alcohol Program	41	36	40
Fort Peck Youth Program	49	36	33
Tri-County (Carter, Powder River, Fallon)	---	---	8
TOTAL REGION I	865	1,014	945
<u>Region II</u>			
Blackfeet Tribal Alcohol Program	41	262	400
Fort Belknap Alcohol Program	226	104	122
Hill-Top Recovery Center	287	314	458
Providence Resocialization Center	371	504	425
**Rocky Boy Tribal Alcoholism Program	48	---	---
TOTAL REGION II	973	1,184	1,405
<u>Region III</u>			
Alcohol Recovery Center	440	772	257 <sup>2</sup>
Rimrock Guidance Foundation	628	680	451
*Crow Agency	---	610	390
TOTAL REGION III	1,068	2,062	1,098

Region IV

ARA of Southwestern Montana	308	258	232 <sup>3</sup>
Information and Referral (Dillon)	69	92	29
*Community Health Services for Alcoholism	372	---	---
***Boyd's Guest House	---	128	140
Deer Lodge County Alcohol Program	---	96	101
Galen State Hospital	1,806	1,900	1,972
*Powell County Alcohol Program	---	48	47
TOTAL REGION IV	2,555	2,522	2,521

Region V

*Alcohol Service Center for Lincoln Co.	---	104	212
Flathead Alcohol Program	251	310	223
*Missoula Employee Assistance Program	---	4	2
Alcohol Service Center	403	220	238
*Alcohol Action/Western MT Regional Alcohol Services	---	109	251
Missoula Indian Alcohol	---	---	54 <sup>4</sup>
TOTAL REGION V	654	747	980
TOTAL FOR STATE	<u>6,115</u>	<u>7,529</u>	<u>6,949</u>

- 1 Reported only until 9/75 (expired).
- 2 Merged with RGF in 11/76.
- 3 Component of ARA in 9/76.
- 4 Began reporting 2/77.

\*Not funded in 1975.

\*\*\*Not funded in 1976.

In reviewing the total number of alcohol admissions for calendar year 1976 one must remember that these figures do not reflect those clients in treatment as of December 31, 1975, and carried into treatment but not counted as new admissions in calendar year 1976. If the fiscal year 1977 contracted alcohol budget of the Addictive Diseases Bureau is compared with total new admissions for Fiscal Year 1977, the per patient cost is \$146.90; exclusive of Galen.



# CLIENT ADMISSION CHARACTERISTICS

(July 1976 – June 1977)

	ADMISSIONS							
	<u>Region I</u>	<u>Region II</u>	<u>Region III</u>	<u>Region IV</u>	<u>Region V</u>	<u>Galen</u>	<u>Total</u>	
Total Admissions	945	1405	1098	549	980	1972	6949	
SEX								
Female	314	331	232	78	288	318	1561	(22%)
Male	583	1042	866	336	692	1654	5173	(75%)
Unknown	48	32	----	135	----	-----	215	(3%)
AGE								
10–20 years	134	116	44	28	118	61	501	(7%)
21–30 years	279	332	228	80	307	583	1809	(26%)
31–60 years	470	803	716	255	505	1026	3775	(55%)
61 and over	28	122	109	44	50	79	432	(6%)
Unknown	34	32	--	142	--	223	431	(6%)
RACE								
White	576	675	574	368	722	1563	4478	(64%)
Am. Indian	328	689	513	36	247	384	2197	(32%)
Other	7	9	11	4	11	25	67	(1%)
Unknown	34	32	---	141	--	---	207	(3%)
INCOME								
0 – \$3600	440	1001	581	223	515	1482	4242	(61%)
\$3601–\$8500	305	268	229	90	258	47	1197	(17%)
\$8501– above	167	104	146	73	207	78	775	(11%)
Unknown	33	32	142	163	---	365	735	(11%)
EMPLOYMENT								
Employed	431	332	291	139	453	110	1756	(24%)
Unemployed	481	1041	703	235	527	1496	4483	(65%)
Unknown	33	32	104	175	—	366	710	(11%)

<u>County</u>	<u>July</u>	<u>Aug.</u>	<u>Sept.</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>Mar.</u>	<u>Apr.</u>	<u>May</u>	<u>June</u>	<u>TOTALS</u>
Phillips	1	0	1	1	0	0	0	0	0	0	0	0	3
Valley	3	0	2	3	1	0	3	0	3	1	2	0	18
Daniels	0	0	0	0	0	0	0	0	0	0	0	0	0
Sheridan	0	1	0	1	0	0	0	0	0	0	0	0	2
Roosevelt	6	2	4	5	4	1	11	8	8	4	7	9	73
Richland	0	0	1	1	0	1	1	2	2	0	1	1	10
McCone	0	0	0	0	0	0	0	0	0	0	0	0	0
Garfield	0	1	0	1	1	3	0	2	0	0	0	0	8
Prairie	0	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	0	0	0	0	1	2	2	3	3	1	1	1	14
Wibaux	0	0	0	0	0	0	1	0	1	0	0	0	2
Fallon	0	0	0	0	0	0	0	0	0	1	0	0	1
Custer	0	1	0	1	2	0	6	4	2	2	5	2	25
Rosebud	2	5	3	5	5	6	6	4	0	0	4	2	42
Treasure	0	0	0	0	0	0	0	0	0	0	0	2	2
Powder River	0	1	0	1	0	0	0	0	0	0	0	0	2
Carter	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	12	11	11	25	14	13	30	23	19	19	20	17	202

REGION 2

Galen Admissions FY 1977

16.8 per month average

<u>County</u>	<u>July</u>	<u>Aug.</u>	<u>Sept.</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>Mar.</u>	<u>Apr.</u>	<u>May</u>	<u>June</u>	<u>TOTALS</u>
Glacier	5	6	2	2	1	2	3	2	4	1	3	3	34
Toole	0	0	0	0	0	0	0	0	0	2	0	2	4
Liberty	1	0	0	0	0	0	1	0	0	1	0	0	3
Hill	0	1	2	1	0	0	6	4	0	4	1	1	20
Blaine	0	3	2	1	1	5	0	1	1	1	2	1	18
Pondera	0	0	1	0	0	0	1	0	1	0	0	0	3
Teton	0	1	1	0	0	0	3	0	1	0	0	0	6
Choteau	0	0	0	1	1	0	0	0	0	0	0	0	4
Cascade	18	19	21	19	8	18	9	4	15	9	17	9	146
	24	25	29	24	11	25	23	11	22	18	23	17	252

REGION II

Galen Admissions FY 1977

28.0 per month average

<u>County</u>	<u>July</u>	<u>Aug.</u>	<u>Sept.</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>Mar.</u>	<u>Apr.</u>	<u>May</u>	<u>June</u>	<u>TOTALS</u>
Judith Basin	0	0	0	0	0	0	1	0	0	0	1	0	2
Fergus	4	3	3	2	2	1	4	7	2	3	4	2	37
Petroleum	0	0	0	0	0	0	0	0	0	0	0	0	0
Wheatland	2	0	0	0	0	0	0	1	0	0	0	1	4
Golden Valley	0	0	0	0	0	0	0	0	0	0	0	0	0
Musseishell	0	0	1	0	1	0	1	1	2	0	0	0	6
Yellowstone	23	16	33	28	20	21	14	9	12	13	10	18	217
Big Horn	0	0	1	1	3	3	4	2	2	2	3	4	25
Carbon	0	1	1	1	0	2	0	0	1	0	3	0	9
Stillwater	1	0	1	1	0	1	0	1	0	0	1	0	6
Sweetgrass	1	1	0	1	0	2	2	0	0	0	1	0	8
	31	21	40	34	26	30	25	21	19	18	23	25	314

REGION III

Galen Admissions FY 1977

28.54 per month average

<u>County</u>	<u>July</u>	<u>Aug.</u>	<u>Sept.</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>Mar.</u>	<u>Apr.</u>	<u>May</u>	<u>June</u>	<u>TOTALS</u>
Lewis & Clark	7	9	10	10	14	15	15	12	14	15	6	12	139
Powell	2	7	8	6	3	3	10	11	5	9	4	2	70
Granite	1	0	0	1	0	1	0	1	2	3	0	1	10
Deer Lodge	11	7	11	25	18	19	16	16	19	17	11	12	182
Beaverhead	5	5	9	5	2	15	8	4	2	2	10	11	78
Meagher	1	0	1	0	1	0	1	1	0	1	1	0	7
Broadwater	0	1	0	0	0	3	2	2	1	0	1	0	10
Jefferson	1	1	1	1	1	2	1	1	2	0	2	0	13
Silver Bow	27	20	31	39	43	31	28	17	24	35	26	20	366
Madison	0	0	0	2	0	0	1	2	0	1	2	0	3
Gallatin	2	5	3	2	3	3	4	2	3	3	4	9	42
Park	3	3	5	4	3	7	0	3	3	3	1	4	39
	60	68	79	95	88	99	86	72	74	89	68	80	958

REGION IV

Galen Admissions FY 1977

79.83 per month average

<u>County</u>	<u>July</u>	<u>Aug.</u>	<u>Sept.</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>Mar.</u>	<u>Apr.</u>	<u>May</u>	<u>June</u>	<u>TOTALS</u>
Missoula	15	14	11	10	11	8	14	12	16	15	15	11	142
Ravalli	2	1	2	1	2	1	3	2	2	1	2	2	21
Lake	4	2	0	1	0	0	0	5	1	0	2	2	17
Mineral	0	0	0	1	0	1	0	0	1	0	0	1	4
Sanders	1	1	1	1	1	1	2	0	1	0	0	2	11
Flathead	9	6	4	4	3	8	5	13	11	5	8	5	81
Lincoln	1	2	7	5	5	5	8	5	8	6	3	8	63
	32	26	25	23	22	24	32	37	40	27	20	31	339

REGION V

Galen Admissions FY 1977

28.5 per month average

## SECTION 5

LIST OF STATE-APPROVED ALCOHOL PROGRAMS

TECHNICAL ASSISTANCE FORMS GIVEN TO PROGRAMS REQUESTING  
STATE-APPROVAL

PROGRAM EVALUATION HANDBOOK FOR ALCOHOLISM TREATMENT  
PROGRAMS





STATE-APPROVED ALCOHOL PROGRAMS

Alcohol Service Center of Lincoln County  
Royce Gilbertson, Director  
Libby, Montana  
Phone 293-7731

Blackfeet Tribal Alcoholism Program  
Margaret Kennedy, Director  
Box 426  
Blackfeet Reservation, Browning, Montana  
Phone 338-7178

Boyd's Guest House  
Boyd Andrew, Director  
410 9th Avenue, Helena, Montana  
Phone 443-2343

Care Unit  
Robert Farren, Director  
Silver Bow General Hospital, Butte, Montana  
Phone 792-9176

Carter, Fallon, Powder River Alcohol & Drug Program  
Doug Austin, Director  
10 W. Fallon Avenue, Baker, Montana  
Phone 778-2944

Fort Belknap Tribal Alcoholism Program  
Florence Cole, Director  
Fort Belknap Reservation, Harlem, Montana  
Phone 353-2731

Fort Peck Tribal Alcoholism Program  
Melvin Eagleman, Director  
Box 307, Poplar, Montana  
Phone 768-3852

Galen State Hospital, Alcoholism Prevention Center  
Don Holmes, Director  
Route 1, Galen, Montana  
Phone 693-2281

Hill-Top Recovery Alcoholism Program  
George Bowery, Director  
Box 750, Havre, Montana  
Phone 265-9665

Missoula County General Hospital  
J.P. Smith, Director  
300 N. 2nd Street, Missoula, Montana  
Phone 542-2191

Central Montana Family Services  
Gordon Lindley, Director  
Box 963, Lewistown, Montana

Custer County Alcohol Program  
Jim Irvin, Director  
Custer County Courthouse, Miles City, Montana  
Phone 232-6542

Crow Reservation Alcoholism Program  
Ben Jefferson, Director  
Crow Agency, Montana  
Phone 638-2662

Deer Lodge Community Alcohol Program  
Jim Weist, Director  
600 Oak, Community Hospital, Anaconda, Montana  
Phone 563-5262

District I Alcoholism Council  
Herb Sukut, Director  
Box 852, Glasgow, Montana

District II Alcoholism Program  
Ron Hjelmstad, Director  
Sheridan County Courthouse, Plentywood, Montana  
Phone 765-2530

Flathead Alcoholism & Drug Abuse Center  
Harold Campbell, Director  
Box 270, Ronan, Montana  
Phone 676-0596

Missoula Indian Alcohol and Drug Program  
Tom Jones, Director  
401 N. Railroad, Missoula, Montana  
Phone 721-2700

Northwest Montana Alcohol and Drug Center  
Harold Schutt, Director  
944 S. Main, Kalispell, Montana  
Phone 755-6453

Park County Problem Drinking Center  
Mary Long, Director  
107 W. Callendar, Livingston, Montana  
Phone 222-2812

Powell County Alcoholism Center  
Paul Miller, Director  
309 Missouri Avenue, Deer Lodge, Montana  
Phone 846-3443

Providence Alcoholism Center  
Dick Baumberger, Director  
920 4th Avenue N., Great Falls, Montana  
Phone 727-2512

Rimrock Guidance Foundation  
Howard Simmons, Director  
923 N. 29th St., Billings, Montana  
Phone 248-3175

Rosebud County Alcoholism Program  
Harold Selvig, Director  
Box 224, Forsyth, Montana  
Phone 356-2670

Sanders County Chemical Dependency Program  
Frank Humble, Director  
Box 940, Thompson Falls, Montana  
Phone 827-4241

South Central Mental Health Center  
Bryce Hughett, Director  
1245 N. 29th Street, Billings, Montana  
Phone 252-5658

Southwest Montana Alcohol Program  
Jim Scott, Director  
801 N. Last Chance Gulch, Helena, Montana  
Phone 442-0710

Western Montana Regional Alcoholism Services  
Marie Morton, Director  
612 S. Higgins, Missoula, Montana  
Phone 728-7712

State of Montana  
Department of Institutions  
Adaptive Services Division



GOVERNOR  
THOMAS L. JUDGE

DIRECTOR  
ROBERT H. MATTSON




DIVISION DIRECTOR  
LAURANCE B. CARLSON

Helena, 59601

July 12, 1977

TO: Alcoholism Treatment Programs Requesting State Approval

FROM: Michael A. Murray, Administrator,   
Alcohol & Drug Abuse Division

SUBJECT: APPROVAL PROCESS

In order to obtain State approval by the Alcohol & Drug Abuse Division programs must complete the following process:

- (1) A written request for approval must be made to the Alcohol & Drug Abuse Division.
- (2) Upon receipt of the request a technical assistance visit will be scheduled.
- (3) During the technical assistance visit the check list will be provided and explained. The purpose of technical assistance is to give the programs a basic understanding of HOW to proceed in completing the required checklist and corresponding documentation for approval.
- (4) Complete the check list and submit the required documentation itemized in the check list to the Alcohol & Drug Abuse Division.
- (5) Upon review of documentation submitted, the evaluation unit of the Alcohol & Drug Abuse Division will schedule an on-site evaluation.
- (6) Approval is granted after the on-site evaluation providing the program is in compliance.

The enclosed check list must be completed and the corresponding documents submitted before an on-site evaluation can be scheduled.

The following instructions will be of assistance in completing the check list.

- o On page 1, Overview of Services, a program must check at least three services, i.e., I Management and Support Services (required); II Aftercare Services (required); and, the service(s) you wish to provide.
- o Section I - Management & Support Services covers pages 2 through 5. This section has three components:
  - A. Organization & Program Management
  - B. Personnel Management & Staff Development
  - C. Financial Management

In total, this section summarizes the requirements mandated by Title 80, Chapter 27, R.C.M. 1947, and Montana Administrative Code, Volume 4, Part 1, Title 20, Chapter 3.

- o Section II, Aftercare Services summarizes the requirements which insure the mandated "Continuity of Care" (refers to above law).
- o The remaining sections (page 7) list the specific services you may wish to provide and instructions are contained therein.

MAM:ab

## OVERVIEW OF SERVICES

**Please check the services for which you wish approval.**

- ☐ I. Management and Support Services
  - A. Organization and Program Management
  - B. Personnel Management and Staff Development
  - C. Financial Management
- ☐ II. Aftercare Services
- ☐ III. Emergency/Detoxification Service
- ☐ IV. Intermediate Care Services
- ☐ V. Out-patient Services

NOTE: Sections I and II must be completed for all programs in addition to the program component for which you are applying.

Example: A program providing detoxification services would be required to meet all the criteria contained in:

1. Management and Support
2. Aftercare
3. Emergency/Detoxification

## 1. MANAGEMENT AND SUPPORT SERVICES

### A. Organization and Program Management Systems

#### 1. STRUCTURE

Submit the following documentation: **(Check off as each item is completed. \*)**

- ☐ a. Organizational Chart (include all components)
- ☐ b. Goals and measureable objectives (approved by governing body)
  - ☐ ● document how goals and objectives were established
  - ☐ ● document how goals and objectives are communicated to staff and community
  - ☐ ● document how goals and objectives are monitored
- ☐ c. By-laws (non-government agencies only)
- ☐ d. Governing body names
- ☐ e. Roles, functions, responsibilities of governing body
- ☐ f. Minutes of last 12 board meetings
- ☐ g. Financial policies and placements
- ☐ h. Description of facilities
  - ☐ ● documentation of licensure (residential only)
  - ☐ ● documentation of total amount of liability insurance
- ☐ i. Submit documentation stating person who is responsible for.
  - ☐ ● Personnel
  - ☐ ● Training
  - ☐ ● Accounting
  - ☐ ● Client Treatment
- ☐ j. Submit sub-contracts or service agreements your program has with other agencies to provide services.

\* Submit to the Alcohol & Drug Abuse Division, when all items are checked off.

## 2. PROGRAM OPERATION

a. Submit a policy and procedures manual which will document the following. **(Check off as each item is completed\*.)**

- ☐ ● Treatment philosophy
- ☐ ● Scope of services and treatment regimes
- ☐ ● Encouragement of voluntary treatment
- ☐ ● Diagnostic groups to be served
- ☐ ● Non-discrimination policy
- ☐ ● Length of stay policy - develop for each component
- ☐ ● Admission procedures - develop for each component
- ☐ ● Individual treatment plan procedures - develop for each component
- ☐ ● Assignment to appropriate type of care - one may cover all components
- ☐ ● Referral procedures
- ☐ ● Discharge procedures - develop for each component
- ☐ ● Evaluation procedures
- ☐ ● Transportation procedures
- ☐ ● Medication procedures - (for residential program only)
- ☐ ● 24-hour 7-day coverage policy
- ☐ ● Client policy

\* Submit to the Alcohol & Drug Abuse Division, when all items are checked off



**B. Personnel Management and Staff Development**

(Check off as each item is completed.)\*

- ☐ 1. Submit present number of treatment staff (name & title).
- ☐ 2. Submit number of treatment staff terminated in last six months.
- ☐ 3. Submit number of positions budgeted for and positions currently vacant. State length of time positions have been vacant.
- ☐ 4. Submit latest staff evaluation.
- ☐ 5. Submit documentation of staff training during past six months.
- ☐ 6. Submit a personnel manual which includes:
  - ☐ a. Staff organizational chart
  - ☐ b. Staffing patterns
  - ☐ c. Job descriptions
  - ☐ d. Pay scale and plan
  - ☐ e. Staff certification (when developed)
  - ☐ f. Staff training and development
  - ☐ g. Personnel evaluation
  - ☐ h. Policies on volunteer help
  - ☐ i. Hiring procedures
  - ☐ j. Leave policies
  - ☐ k. Affirmative Action policy

**C. Financial Management Systems**

(Check off as each item is completed.)\*

- ☐ 1. Submit current and historical financial condition.  
(See Exhibit II-1, page III-3)
- ☐ 2. Submit third party payment plan if in existence.
- ☐ 3. Submit federal and other grants if applicable.
- ☐ 4. Submit monthly financial reports for past six months.
- ☐ 5. Submit budget vs. actual expenditures.  
(See Exhibit III-3, page III-8)
- ☐ 6. Submit a copy of the most recent audit.

\* Submit to the Alcohol & Drug Abuse Division, when all items are checked off.

## II. AFTERCARE SERVICES

A. Aftercare-defined as that process of providing continued contacts with terminated clients, which will support and increase the gains made to date in the treatment process.

B. The Aftercare component shall have a written operational plan describing the following:

(Check off as each item is completed. \*)

- ☐ 1. Primary Aftercare procedures; ie. procedure which specify frequency, type of service offered and methodology.
- ☐ 2. Measurable objectives.
- ☐ 3. Detailed job descriptions, which delineate, supervisory positions, lines of authority and roles and responsibilities of Aftercare personnel.
- ☐ 4. Methods of personnel utilization; ie. total number of staff and their function within the entire program.
- ☐ 5. List of referral sources utilized by your program. Please include those that provide services not available through the program.
- ☐ 6. Referral procedures which insure continuity of care.
- ☐ 7. A written individualized treatment plan designed to establish continuing contact for support of each client.
  - ☐ a. Treatment shall be designed to meet the needs of the individual based on problems identified.
  - ☐ b. Indicate the nature of the client's participation in formulating his/her **treatment plan**.
  - ☐ c. Provisions for periodic review and updating of **treatment plan**
- ☐ 8. Criteria for re-entry into primary treatment and for termination of Aftercare services. Describe methods utilized for conveying this to clients.
- ☐ 9. There shall be a written plan for the training of all Aftercare personnel.
- ☐ 10. There shall be documentation verifying that a review of Aftercare records is conducted at least quarterly to evaluate the delivery of Aftercare services.
- ☐ 11. Submit a budget for providing Aftercare services.

\* Submit to the Alcohol & Drug Abuse Division, when all items are checked off.

### **III. EMERGENCY/DETOXIFICATION**

- A. This component shall provide 24 hour availability of the following services to all persons incapacitated by alcohol.
  - 1. Immediate medical evaluation and care.
  - 2. Supervision of persons by properly trained staff.
  - 3. Evaluation of client's needs, leading to development of a plan for continuing care.
  - 4. Effective transportation services.
- B. The emergency/detoxification program may be either a free standing unit or beds specifically designated for withdrawal from alcohol in a hospital or other facility.
- C. Refer to the evaluation handbook and the approval booklet for specific criteria.

### **VI. INTERMEDIATE CARE**

- A. This component shall provide diagnostic and primary alcoholism services in an organized therapeutic environment which a full or partial setting can provide. Services shall include recreational, vocational, and screening for medical problems.
- B. Refer to the evaluation handbook and the approval booklet (requirements for residential programs and the individual component criteria) for specific criteria.

### **V. OUT-PATIENT CARE**

- A. This component shall provide a variety of diagnostic reviews and primary alcoholism services on both a scheduled and non-scheduled basis in a non-residential setting.
- B. Refer to the evaluation handbook and approval booklet for specific criteria.

MONTANA DEPARTMENT OF INSTITUTIONS  
ALCOHOL & DRUG ABUSE DIVISION

---

PROGRAM EVALUATION HANDBOOK  
FOR  
ALCOHOLISM TREATMENT PROGRAMS

---

November, 1976

MONTANA DEPARTMENT OF INSTITUTIONS  
ALCOHOL & DRUG ABUSE DIVISION

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PROGRAM EVALUATION HANDBOOK  
FOR  
ALCOHOLISM TREATMENT PROGRAMS

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## INTRODUCTION

### A. BACKGROUND:

During the past two years, significant organization change has occurred within the Montana Department of Institutions (the Department). A primary change has been increased centralization of Department management and administrative functions. For example, Montana House Bill 699 mandated consolidation of all functions of State Government dealing with Addictive Diseases into the Department. This consolidation brought together under the Addictive Diseases Bureau (ADB), four existing organization units dealing with drug abuse and alcoholism treatment. They were:

- Single State Agency for Drug Abuse Treatment Coordination
- Southwestern Montana Drug Treatment Program
- Single State Alcohol Authority
- Montana Alcohol Service Center

Further, an Adaptive Services Division (ASD) was created within the Department with a single administrator responsible for the new ADB, the Mental Health Bureau (MHB) and all state institutions for the retarded, mentally ill and elderly. This reorganization brought the two major service components of the Department (institutional care and community-based care) under one organization unit.

At the time of the reorganization, the scope of ASD responsibilities for community-based services included approximately 31 mental health centers or satellites, 15 outpatient or residential drug abuse treatment programs and 22 primary providers of alcoholism treatment services. Authorized Federal and State combined expenditures for FY 1977 were approximately 5.8 million dollars.

The single most important responsibility of the ASD is to provide overall direction and monitoring of these community-based programs to help ensure statewide program compliance with Federal and State standards. This responsibility is clearly mandated by Montana House Bill 289 which, in part, requires biannual review of community-based programs to which state funds have been allocated. As the number and diversity of local treatment programs have increased, the requirements for program accountability have become more complex. In the past, there existed numerous program evaluation methods and formats which are not satisfactory for current Department needs for the following reasons:

- Evaluation criteria have not been sufficiently responsive to State requirements.
- Program evaluations have not been performed on a regular or timely basis.
- Evaluation criteria for mental health, drug abuse treatment and alcoholism treatment programs have not been uniform in content or approach.

-Methods and procedures for conducting program evaluations were poorly documented resulting in lack of objectivity and incompleteness of findings and suggested corrective action.

To help correct these weaknesses and to carry out the responsibility for monitoring and evaluation, the ASD has developed this handbook for use by state and local agency personnel to achieve the following major purposes.

B. PURPOSE OF THE PROGRAM EVALUATION PROCESS:

The purpose of the program evaluation process as outlined in this handbook includes primary and secondary objectives:

Primary objectives are:

- To improve program performance and client service levels.
- To help ensure statewide compliance with Federal and State standards.
- To help achieve efficiency and economy in program operations.

Secondary objectives are:

- To assist in determination of program funding levels and approval of contracts.
- To determine areas of needed technical assistance and training.
- To gather data for development of additional state standards for program performance.

The guidelines and procedures presented in this handbook are intended to help achieve these objectives. However, the procedures included cannot supplant the evaluator's judgment as to the optimal approach to follow in verifying the existence or quality of all required operations. In many instances, additional work may be necessary to fully understand and assess program activities.

C. SUMMARY OF HANDBOOK CONTENTS:

The handbook is organized around three primary sections. Section I is a general introduction to the background and purpose of the program evaluation process. Section II outlines the general steps to be taken in conducting the on-site program evaluation and is intended for use by ASD personnel. This section presents an outline of important management considerations in achieving efficient and effective evaluation of numerous community-based programs. Section III includes a summary of Federal and State standards and detailed evaluation procedures to determine whether standards are met for each of four evaluation areas:

- Organization and Program Management
- Personnel Management and Staff Development
- Financial Management
- Client Treatment and Census

This section is intended for use not only by ASD program evaluation personnel but also by all community-based program management staff for conducting self-evaluation. Attached to the handbook is an appendix which includes a program evaluation checklist for use in summarizing findings and recommendations resulting from the evaluation process.



A. OVERVIEW OF AN ON-SITE PROGRAM EVALUATION:

The on-site evaluation provides an opportunity for the program evaluator to assess the controls and management systems within a program. For the purposes of this handbook, a program is defined as a community-based service provider of mental health, drug abuse treatment or alcoholism treatment services. An assessment of management systems enables the evaluator to determine whether a program is operating in a manner consistent with Federal and State program standards and accountability requirements. Program management is defined in terms of four basic components:

- Organization and Program Management Systems
- Personnel and Staff Development Systems
- Financial Management Systems
- Client Treatment Systems

The organization system consists of methods by which the program manages itself. The personnel and staff development system include the policies and procedures used to attract, maintain and develop staff. The financial system consists of guidelines and procedures which govern accounting, budgeting and equipment procurement activities. The client treatment system consists of procedures, documentation and reporting which relate to client treatment activities.

Each of these systems may be evaluated using one or all of the following methods of program assessment:

- Review of written policies and procedures
- Review of program files
- Interviews with staff and management personnel

Evaluation results should be completely documented in evaluator notes indicating the names of staff interviewed, date of interview and documents reviewed. In addition, summary comments should be included indicating the rationale used in determining whether the program meets standards. Then, results are summarized on the program evaluation checklist displayed in the appendix of the handbook. This checklist is designed for the most comprehensive evaluations and is organized according to the four basic systems of program management. It is important to point out here that the checklist provides for only a summary of findings and should not be used until after evaluation procedures have been performed and documented.

Three types of site visits are defined - comprehensive, interim and follow-up. Each has a different focus and requires a different level of manpower, but all follow the same basic phases of performance. Each type is defined in detail later in this section.

The program evaluation consists of the following phases:

- Scheduling
- Pre-planning
- Entry interview
- Work planning
- Conducting the review
- Exit interview
- Preparation and distribution of the final report
- Conducting the debriefing interviews with the program director

A discussion of the three types of evaluation and each phase of the evaluation process makes up the remainder of this section of the handbook.

#### B. TYPES OF EVALUATION:

In order to provide evaluation flexibility, three types of program evaluation are recommended. The timing and use of each type is determined from results of previous evaluations by the ADB or MHB Bureau Chief in conjunction with the ASD Administrator and the program evaluation supervisor. However, at least one comprehensive on-site visit per year is recommended.

- Comprehensive evaluations focus on all program management systems. The objective of these evaluations is to determine whether the entire program meets State and Federal standards, to evaluate the quality of Financial Management and to validate reported client treatment data.

The time required for a comprehensive evaluation will depend largely on program size in terms of staff and client volume and the number of program facilities. However, even in the larger programs, comprehensive evaluations, including preparation of the final report should require no more than four man-weeks of effort. For example, a large community mental health center (excluding satellites which should be evaluated separately after the center is evaluated) should require the following manpower:

- .One person for three weeks (two weeks on-site) to conduct the Organization, Personnel and Client Treatment systems evaluations including preparation of the final report.
- .One person for one week on-site to conduct the Financial Management evaluation including preparation of the final report.

Again, at least one comprehensive evaluation of each program should be performed annually.

- Interim evaluations may consist of either an in-depth evaluation of one or more management systems or a less intensive evaluation of all systems as deemed appropriate by ASD management. The objective of the interim evaluation is to assess

program management progress during the year between comprehensive evaluations. Three to five man-days are generally required to perform the interim evaluation.

-Follow-up evaluations are initiated by specific problems uncovered during a previous evaluation. This type will usually consist of an in-depth review of one or more components within a particular management system, i.e. Organization, Personnel, etc. The objective of the follow-up evaluation is to determine whether the program has implemented specific corrective actions by ASD established due dates. Normally, one day or less is required for a follow-up evaluation.

It should be noted that other types of site visits may be required from time-to-time to provide programs with technical assistance, advice, or other specific information such as notifying the program of new standards concerning program operations.

#### C. SCHEDULING:

Each Bureau Chief (ADB and MHB) is responsible for preparing a tentative schedule of evaluations for programs under his jurisdiction. The tentative schedules should be finalized in conjunction with the ASD Administrator and the program evaluation supervisor. Proper planning for comprehensive evaluations ensures that sufficient time is available for the site visit, that staff will be available and that all programs are evaluated in a timely manner. Planning for comprehensive evaluations occurs once a year. During the scheduling phase, Bureau Chiefs should ensure that a comprehensive evaluation of each program is scheduled.

Interim evaluations are scheduled on a quarterly basis, as needed, for the subsequent three month period. The quarterly plans should be consistent with annual plans to avoid duplicate scheduling.

Follow-up evaluations are scheduled to coincide with established due dates for corrective action resulting from comprehensive or interim evaluations.

#### D. PRE-PLANNING:

Pre-planning is the first phase of the evaluation process. This phase includes three major steps: a) defining the scope of the evaluation, b) making appointments, and c) reviewing available information at the central office.

##### -Definition of Scope:

During the pre-planning phase, the ADB or MHB Bureau Chief is responsible for outlining to the program evaluation supervisor the desired scope of work for the on-site visit. Scope depends on the type of evaluation selected. For comprehensive evaluations, a detailed review of all program management systems is

required as outlined in Section III of the handbook. For interim or follow-up evaluations, the areas to be covered should be specifically identified.

-Making Appointments:

This activity consists of determining the date of the visit, coordinating the visit with the designated program, making appropriate appointments, and confirming the evaluation of schedules.

The date and time of the review will depend upon the program's normal working hours and upon the availability of key program personnel. In most instances, it is advantageous to ensure the availability of the program director and other administrative personnel prior to the visit. Appointments should be made with the program director, either by telephone or letter, several weeks in advance of the visit. When making appointments, the program evaluator should confirm the availability of personnel for interviews and outline the scope and purpose of the visit. This establishes a mutual understanding between the director and the evaluator and helps to ensure that on-site review time is most efficiently used.

If appointments are made by telephone, a letter should be sent to the program director to ensure that both parties have agreed on the same date and timing. A misunderstanding of the specified time and review activities can present problems with the availability of key personnel.

-Review Information in the Central Office:

Prior to the visit, the program evaluator should spend several hours reviewing the program information at the central office. The types of information to be reviewed include:

- .Previous site visit reports
- .Pre-audit and audit reports, if available
- .Funding application or contracts and line item budget
- .Program application review comments
- .Voucher submissions
- .Correspondence
- .The most recent program report showing the number of clients served by service program.

The extent of pre-visit file review will depend upon the program evaluator's knowledge of the program, the type of review scheduled, and the elapsed time since the last comprehensive review.

F. ENTRY INTERVIEW:

The entry interview is the second phase of the program evaluation.

Upon arrival at the program, the program evaluator will generally contact the program director. During the preliminary interview with the director, the evaluator is responsible for defining his/her agenda, confirming the persons to be interviewed, and indicating the files to be reviewed. Specific topics to be discussed in the interview include:

- Introduction of the evaluation team members and program staff.
- Purpose of the evaluation and areas to be covered.
- An overview of the program staff needed to assist the evaluation team.
- The date and content of the exit interview.
- The timing and distribution of the final report including a discussion of the debriefing interview with the ASD Administrator.
- Workspace for the evaluation team.

After the program director and his staff have had an opportunity to question the evaluation team members about the visit, the program director should be requested to provide an overview of operations covering the following topics:

- A description of the organization chart including the names and locations of management or supervisory personnel needed for the evaluation such as the directors of training, personnel, client treatment and accounting.
- An overview of services provided and the facilities used.
- The location of policy material such as manuals and procedures to determine if the review of policies should be shared among team members.

F. WORK PLANNING:

The purpose of the work planning phase is to determine the estimated time required for evaluation of each management system and to assign specific duties to each team member. Immediately following the entry interview, the evaluation team should meet and discuss the results of the entry interview. At this meeting, final agreements are made about who will conduct what portion of the evaluation and the expected completion dates. If feasible, an evaluation schedule should be prepared and given to the program director showing expected times or dates that various program staff or facilities will be contacted and by which team members.

G. CONDUCTING THE EVALUATION:

During the comprehensive evaluation of each review area, the evaluator should follow the detailed instructions and procedures outlined in Section III of the handbook. However, if additional methods or procedures are necessary, a description of the methods used should be included in supporting documentation. Documentation of evaluation procedures and findings is viewed as an integral part of the total evaluation process. The effectiveness of the evaluation effort is directly related to the quality and completeness

of evidence supporting conclusions that a program meets or does not meet standards. In addition, the evaluation process results in an easy to prepare and accurate final report if evaluators follow evaluation procedures and prepare complete documentation showing evidence of findings.

Evaluation procedures are organized to facilitate a step-by-step cumulative understanding of a program's internal management and service delivery systems. Following the instructions of each evaluation guide, the evaluator should keep the following principles in mind:

- Evaluators should familiarize themselves with the content of the guides before use. Prior preparation will increase the efficiency in conducting procedures and the quality of documentation.
- Evaluators should follow the guides as closely and sequentially as feasible to help ensure that all appropriate procedures are performed and questions asked.
- In summarizing results, the evaluators should restate questions asked and summarize steps taken. For example, . . . "When asked who was responsible for in-service training, staff indicated that the responsibility had not been delegated to any particular individual." "The staff interviewed were . . ." Procedures not performed or questions not asked should also be recorded. This method of documentation will help ensure that during final report preparation and program debriefing, the evaluator will not have to rely on memory of steps taken or staff interviewed to interpret his/her notes.

Following the above principles will enhance the overall process of conducting the evaluation and will result in a well organized set of workpapers for later reference and completion of the evaluation checklist and final report.

-Use of the Evaluation Guides and Documentation Worksheets:

The four evaluation guides are intended for use as a handbook of instructions in performing a program evaluation. Detailed notes resulting from evaluation procedures should be kept separate from the guides so that each guide may be used indefinitely by a program evaluator. Several copies of each documentation worksheet, the financial management internal controls questionnaire and the program evaluation checklist should be contained in a central file at the ASD central office for use during an on-site evaluation.

-Organization of Workpapers:

The workpapers and other documents supporting each separate evaluation should be organized within five separate folders,

each labeled with the agency name and dates and type of review. (For interim evaluations, fewer folders may be required, depending upon the scope of evaluation.) The specific content of Folder One and general content of Folders Two through Five should be as follows:

.Folder One, labeled "General Administrative Summary" should include:

(-) A face sheet showing:

Name of Program  
Facility Evaluated  
Type of Evaluation  
Date of Evaluation  
Evaluated By  
Reviewed By  
Date of Last Evaluation

(-) The Evaluation Final Report

(-) The completed Program Evaluation Checklist for all areas of evaluation.

.Folders Two through Five should contain supporting documentation for the findings using the Program Evaluation Guides and should, therefore, be labeled so that they correspond to the appropriate guides, as follows:

- (-) Organization and Program Management
- (-) Personnel Management and Staff Development
- (-) Financial Management
- (-) Client Treatment and Census

The content of Folders Two through Five represent the evaluator's documentation of steps taken and conclusions reached in the program evaluation process. As such, it will be used both as the basis for the preparation of the Evaluation Final Report and as the justification to the agency of all statements made in that report! It is, therefore, important that documentation be precise and well ordered, in a format facilitating final report preparation and easy access during agency debriefing.

.Each of Folders Two through Five should contain all supporting documentation for the findings in that area of evaluation. This documentation may include interview notes, copies of contracts and other official documents, agency pamphlets and manuals, documentation worksheets completed per Guide instructions, and all other working papers pertinent to the identified area of evaluation.

Within each of Folders Two through Five, papers should be organized as follows:

- (-) Sections should be physically separated by 14" x 18" two-hole-punched paper and labeled to correspond with Guide and Checklist sections. Each section should be given a code letter.
- (-) Within sections, papers should be ordered sequentially, i.e., in the order of the Guide procedures which they document, and should be numbered. A section code and page number reference to documentation can then be recorded on the checklist for all findings.
- (-) All papers should be two-hole-punched and fastened into folders.
- (-) Each file should contain a table of contents.

-Program Evaluation Checklist:

A program evaluation checklist is provided in Appendix A of the handbook. The checklist is designed to record the results of the evaluation to summarize recommendations for corrective action. Further, the checklist provides a column in which to record the location of supporting evidence in evaluation workpapers. The checklist is to be completed after all evaluation steps are completed and is used as a basis for the exit conference and final report. For each area of review, one of three findings is possible:

.Acceptable - No Action:

The program is functioning well in this area and there are no recommendations for improvement.

.Acceptable - Action Recommended:

The program's performance can be improved, but currently a deficiency in this area is not interfering with program operations.

.Unacceptable - Action Required:

The program is seriously deficient in an area and corrective action is required.

All findings which are unacceptable should be followed with a summary statement of the recommended action. A category checked "Acceptable - Action Recommended" should have a recommended action. There should not be a recommendation after any category checked "Acceptable - No Action."

If a category has not been reviewed, an "N/R" should be shown in the "No Action" column. If the category is not applicable to the type of review, an "N/A" should be entered in the "No Action" column.



## H. EXIT INTERVIEW:

The exit interview provides an opportunity for the program evaluator to relate review findings to the program director. An exit interview is required for each visit, although the depth of the interview will vary with the type of visit.

In a comprehensive visit, the exit interview should begin with a discussion of the work performed as was outlined in the entry interview. Then, the program evaluator should discuss the strengths and weaknesses found during the review along with specific recommendations for corrective action. This data should be already summarized on the evaluation checklist as described above and the checklist should be used for the exit interview. After this discussion and the resolution of any contended issues, the program evaluator should again describe the timing and distribution for the final report.

The interim evaluation exit interview is structured in the same way as for the comprehensive evaluation; however, strengths and weaknesses will be limited to those topics reviewed.

An exit interview for a follow-up visit is used to summarize findings, and, if prior recommendations have not been implemented, to report the lack of program action and the reasons given by the program director.

## I. PREPARATION AND DISTRIBUTION OF THE FINAL REPORT:

The comprehensive program evaluation final report is intended to be brief and outlines the evaluation findings and recommendations. During the field testing of this handbook, a final report was prepared for an alcoholism treatment program and should be used as a guide for all reports on comprehensive evaluations. Content of this report includes the following:

### -Cover Letter

### -Program Overview

- A. General information and services provided.
- B. Location of facilities including program activities or services performed at each facility.
- C. The present organization structure of the program.

### -Findings and Recommendations

- A. Organization and Program Management
- B. Personnel Management and Staff Development
- C. Financial Management
- D. Client Treatment and Census

## -Appendix

- A. Membership of the Governing Board
- B. Estimated Income and Expenses, 1974-1976
- C. Budgeted vs. Actual Income and Expenses, January-April, 1976
- D. Utilization of Inpatient and Residential Facilities and Reported vs. Documented Outpatient Census
- E. Content of Client Case Records
- F. Analysis of Support Service Contacts
- G. Analysis of Personnel File Content

Findings of strengths and weaknesses are based on the program's implementation of required program standards as summarized in the evaluation guides. Specifically, if a particular standard is being met, it is considered a program strength and if not met, it is considered a weakness. As pointed out in Section II-G (above), it is extremely important that each finding be supported by detailed documentation in the program-evaluation files. This is to ensure that the finding is based on actual performance of evaluation procedures and can be referenced in the event a program director or other report readers desire further substantiation of the finding.

The final report should be prepared in draft form by the program evaluator and submitted to the appropriate Bureau Chief and ASD Administrator for review. Upon approval of report content and preparation of necessary revisions, copies should be distributed to:

- The chairman of the program governing or advisory board, and,
- The program director.

Attached to the report should be a cover letter from the ASD Administrator in which a date is established for an evaluation debriefing to be held at the ASD central office (see below).

For interim evaluations, only those areas assessed should be included in the report. Further, in place of the "program overview" section, a summary should be prepared outlining the major focus of the interim assessment based on the findings of the previous comprehensive evaluation.

For follow-up reviews, a summary memorandum should be prepared outlining the progress to date on specific problem areas which were to be corrected as agreed upon in the evaluation debriefing.

### J. CONDUCTING THE PROGRAM EVALUATION DEBRIEFING:

The purpose of the debriefing interview is to obtain agreement between ASD management and the program director about the priorities and due dates for program corrective actions. Attendance should include:

- The ASD Administrator
- The appropriate Bureau Chief
- The program evaluation Unit Supervisor
- The local Program Director
- The local program Board Chairman or Representative

The debriefing occurs approximately 2-3 weeks after the evaluation final report has been delivered to the program. The initial debriefing activity is to verify with the program director that the final report accurately reflects the status of program operations at the time of on-site evaluation. In some cases, the program director may request further substantiation of report findings. Should this occur, the program evaluation unit supervisor should be asked to summarize the basis of findings as documented in detailed notes in the evaluation files and the source of the indicated program standard.

After contended issues are resolved, the ADB or MHB Bureau Chief should outline which findings are most critical requiring uppermost priority for corrective action. While all standards in the handbook are required for program implementation, the following are probably the most urgent for correction to continue present funding levels:

- The documented client census or active caseload should be of sufficient size to require present funding amounts.
- Results of the financial management evaluation should indicate that the program can maintain required levels of local cash contributions and is adequately in control of financial operations.
- The frequency of client contact and quality of case record documentation should indicate that the program is in control of the service delivery process. This is to help insure that clients are receiving necessary services and that staff time is efficiently utilized. Two major aspects of this determination is that treatment contacts are routinely documented in case records and that individualized client treatment plans and progress notes are current.
- Evaluation results of overall program management systems such as organization and personnel should indicate that the program Board of Directors and the program director are maintaining leadership and control of the program's staff and operation. This is indicated by sound personnel policies and staff performance evaluation, continuing use of program objectives to monitor program performance, and well documented operating policies and procedures.

During the debriefing interview, each weakness listed in the final report should be discussed. The program director should explain the planned corrective actions and expected due dates for accomplishment. Agreements should be reached between ASD and the

program director about both content and timing of corrective actions. At the conclusion of the debriefing, the program director should be requested to submit to the ADB or MHB Bureau Chief a follow-up written response to the report outlining this corrective action plan. This document should be submitted within two weeks for the debriefing interview and becomes the basis for subsequent interim and follow-up program evaluations.

SECTION I

ORGANIZATION AND PROGRAM MANAGEMENT EVALUATION GUIDE

## I.

### ORGANIZATION AND PROGRAM MANAGEMENT EVALUATION GUIDE

#### A. INTRODUCTION:

Evaluation of the organization and program management system includes review of documents, interviews with staff and a tour of facilities. The review areas include:

- organization structure
- program goals and objectives
- policies, procedures and required plans
- governing boards and advisory boards
- program self-evaluation
- facilities

The review should begin with interviews with the program director and other appropriate administrative personnel responsible for program management. During the interviews, the evaluator should obtain a general understanding of how the program is managed by obtaining answers to questions listed for each review area. In addition, he should identify the location of supporting documents needed to verify that requirements are being met.

#### B. ORGANIZATION STRUCTURE:

##### Summary of Requirements:

The organization structure should be formally documented on an organization chart reflecting current lines of authority and reporting relationships. This is to help ensure that staff understand their position in the organization and to promote clear communications throughout the organization. To achieve this purpose, a current chart should be available to each staff member.

##### Evaluation Procedures:

#### 1. Development and Communication of Organization Structure:

- a. Obtain or prepare a current organization chart. (This chart will be included in the final report.)

- b. Interview the program director and 3-5 staff and determine the following: (See the "Professional Staff Interview Questionnaire," Exhibit II-2, in the Personnel Management and Staff Development Evaluation Guide.)

.When was the organization chart last updated?

.Does the present organization chart accurately reflect lines of authority and reporting relationships?

.Are the program director and supervisors available to staff for problem solving and direction?

.Do staff believe the organization structure makes sense and do they believe that they have been given adequate instruction and authority to perform assigned functions?

.Who in the organization is responsible for supervision of the following functions: (A single individual should be assigned for each function.)

-Personnel

-Training

-Accounting

-Client Treatment

C. GOALS, OBJECTIVES AND PROGRAM SELF-EVALUATION:

Summary of Requirements:

A written statement of goals and specific and measurable objectives is to be distributed to staff and made available to clients and the community. Monitoring of actual versus scheduled progress in the accomplishment of objectives is to be reported monthly to the Department of Institutions in written form. Responsibility for accomplishment of objectives should be assigned to specific individuals or organizational units.

Governing boards are to provide resources for the program self-evaluation process, which is to include at least their annual review of program compliance with contract requirements.

Evaluation Procedures:

1. Development of Goals and Objectives:

To determine whether a program has developed goals and objectives, obtain a written statement of program goals and objectives and a schedule of dates for their accomplishment. Interview the program director and determine the following:

.How are program goals and objectives established?

.Do they reflect efforts to improve or enhance past performance?

2. Communication of Goals and Objectives:

To assess communication of goals and objectives to staff, clients and the community interview the program director and



3-5 professional staff to obtain the following information:

(See the "Professional Staff Interview Questionnaire," Exhibit II-2, in the Personnel Management and Staff Development Evaluation Guide.)

- a. Are staff aware of current goals and objectives? Do they believe the statement accurately reflects current goals and objectives based on directions received?
- b. What means are used to communicate goals and objectives to clients and the community? Review printed materials such as pamphlets or brochures available to clients and the community.

3. Monitoring of Goals and Objectives:

To determine whether formal monitoring of goals and objectives is done, interview the program director and determine the following:

- a. To whom are responsibilities for achieving and monitoring objectives assigned?
- b. Review files of progress reports to confirm that objectives are formally monitored for achievement at least monthly.

- c. Review documentation of follow-up action taken on findings reported in progress reports. For objectives not achieved by expected due dates, are new due dates established?

4. Performance of Program Self-Evaluation:

To determine whether the program conducts required formal self-evaluation of its compliance with contract requirements, interview the program director and determine the following:

- a. What procedures are used for self-evaluation?
- b. Are formal reports prepared and submitted to the governing or advisory board?
- c. Review written reports of the most recent self-evaluation.  
Is self-evaluation performed at least annually?

D. POLICIES, PROCEDURES AND REQUIRED PLANS:

Summary of Requirements:

Written statements of program policies, procedures and plans are to be available or distributed to staff as appropriate in a format amenable to formal and regular revision and maintenance. The statements are to include, for all programs:

- Plan for Affirmative Action (if the facility receives direct federal funds) including recruiting and hiring policies.
- Annual plan for organized in-service training, including on-going training, orientation for new employees, and supervision of staff; and a policy on educational leave.

- Standards (or qualification requirements) for professional and trained non-professional staff.
- Policy of non-discrimination among clients.
- Accounting policies and procedures as required by the Department of Institutions.
- Individualized Treatment Plan for each client.
- Program service procedures for:
  - Admissions
  - Screening
  - Referral to other agencies and current resource listings
  - Aftercare and follow-up
  - Emergency treatment
- Policies for personnel which should include procedures for recruitment, selection and termination of staff and for:
  - .Wage and Salary Administration
  - .Employee Benefits
  - .Working Hours
  - .Vacation and Sick Leave
  - .Rules of Conduct and Disciplinary Action
  - .Work Performance Evaluation
  - .Arbitration of Employee Grievances

Additional Requirements for Drug Abuse Treatment Programs are:

- Policy for client termination including termination criteria and recording requirements.
- Formal plan for drug abuse prevention and education. The plan is to include:
  - .Defined Target Groups
  - .Goals and Objectives of the Program
  - .Designated Personnel for Program Implementation
  - .Program Content
  - .Methods to be Used
  - .Evaluation Procedures

Additional Requirements for Alcoholism Treatment Programs are:

- Policies for overall operation including scope of services, groups to be served, and methods of service.
- Policy for client transportation.
- Policy for client termination including termination criteria and recording requirements.

-Residential alcoholism treatment programs are required to have:

- .Schedule for recreation and rehabilitation programs.
- .Policy on "length of stay".
- .Policies and procedures for the distribution of medication, administration of first aid and referral for treatment of medical emergencies.

Evaluation Procedures:

1. Development of Required Program Policies, Procedures and Plans:

To assess the program's policy making process, and to determine whether the program has developed required written statements of policy, procedures and plans, interview the program director to determine the following:

- a. Who is responsible for establishing, changing and approving program policies?
- b. What is the role of the governing board in the policy making process? During the review of board meeting minutes (see below) verify that the board actively participates in policy development and approval.
- c. Are there written statements of program policies, procedures and plans? Obtain and review copies of those required and document their existence on the "Policies Documentation Worksheet," Exhibit I-1, indicating the titles of documents and the date they were prepared.

NOTE: If copies of the required written policies, procedures and plans are not centrally located, the evaluator should consider requesting that another member of the evaluation team verify their existence. For example, existence of personnel policies might be verified by the team member performing the evaluation of personnel management and staff development.

EXHIBIT I-1

POLICIES DOCUMENTATION WORKSHEET

PROGRAM NAME: \_\_\_\_\_  
REVIEWED BY: \_\_\_\_\_  
DATE: \_\_\_\_\_

<u>REQUIRED POLICY/PROCEDURE/PLAN</u>	<u>DOCUMENT TITLE</u>	<u>DATE PREPARED</u>
---------------------------------------	-----------------------	----------------------

All Programs

- Plan for Affirmative Action  
(if the facility receives  
direct federal funds) includ-  
ing recruiting and hiring  
policies.
- Annual plan for organized in-  
service training, including  
on-going training, orienta-  
tion for new employees, and  
supervision of staff; and a  
policy on educational leave.
- Standards for professional and  
trained non-professional staff.
- Policy of non-discrimination  
among clients.
- Accounting policies and pro-  
cedures as required by the  
Department of Institutions.
- Individualized Treatment Plan  
for each client.
- Program service procedures for:
  - Admissions
  - Screening
  - Referral to other agencies  
and current resource  
listings
  - Aftercare and follow-up
  - Emergency treatment
- Policies for personnel which  
should include procedures for  
recruitment, selection and  
termination of staff and  
for:

- .Wage and Salary Admini-  
stration
- .Employee Benefits
- .Working Hours
- .Vacation and Sick Leave
- Rules of Conduct and  
Disciplinary Action
- .Work Performance Evalua-  
tion
- .Arbitration of Employee  
Grievances

Additional Requirements for Drug  
Abuse Treatment Programs are:

-Policy for client termina-  
tion including termination  
criteria and recording re-  
quirements.

-Formal plan for drug abuse  
prevention and education.  
The plan is to include:

- .Defined Target Groups
- .Goals and Objectives of  
the Program
- .Designated Personnel for  
Program Implementation
- .Program Content
- .Methods to be Used
- .Evaluation Procedures

Additional Requirements for  
Alcoholism Treatment Programs  
are:

-Policies for overall client  
treatment including scope of  
services, groups to be served,  
and methods of service.

-Policy for client transporta-  
tion.

-Policy for client termina-  
tion including termination  
criteria and recording  
requirements.

REQUIRED POLICY/PROCEDURE/PLAN

DOCUMENT TITLE

DATE PREPARED

-Residential alcoholism  
treatment programs are re-  
quired to have:

.Schedule for recreation  
and rehabilitation pro-  
grams.

.Policy on "length of  
stay".

.Policies and procedures for  
the distribution of medica-  
tion, administration of  
first aid and referral for  
treatment of medical emer-  
gencies.



2. Communication of Program Policies and Procedures:

To assess the extent to which program policies and procedures are communicated to staff, interview the program director and determine the following:

- a. Describe how new and revised policies are communicated to staff?
- b. Does a policy manual exist covering the major aspects of the program? Summarize its contents, i.e., list the general areas it covers.
- c. To whom is the manual distributed?
- d. Is the manual format amenable to formal and regular revision and maintenance? Assess whether the manual provides an overall structure within which individual policy or procedural changes can be documented. The manual should not be just a looseleaf series of policy memos.
- e. Are policies and procedures clearly communicated to staff? Interview one staff member from each of the following staff classifications: clerical, administrative, treatment, to assess this communication. (See the "Professional Staff Interview Questionnaire," Exhibit II-2,

in the Personnel Management and Staff Development Evaluation Guide.)

E. GOVERNING BOARDS AND ADVISORY BOARDS:

Summary of Requirements:

Each non-government agency is to have a governing board with the responsibility to:

- Develop and/or approve by laws and policies and annual agency plans.
- Receive and administer agency funds and resources.
- Meet quarterly (monthly for mental health agencies) and keep meeting minutes.
- Employ, supervise and evaluate the agency director.
- Be representative of the community in membership.

Each community-based, government-administered drug abuse treatment or mental health agency is to have an advisory board, with the responsibility to:

- Assist the agency director or administrator in development of program policy.
- Review annual agency plans and budget.
- Meet quarterly and keep meeting minutes.
- Be representative of the community in membership.

Evaluation Procedures:

1. Presence and Role of Governing Board:

To determine whether a non-government agency has a governing board, and to assess the role it plays in directing and monitoring the agency, perform the following steps:

- a. Interview the agency director to determine whether the agency has a governing board, and how often they meet. Obtain a list of board membership and each members title or background, and identify the location of minutes of board meetings.
- b. Interview the chairman of the governing board to **verify** the role of the board in monitoring and directing the agency, e.g., fiscal accountability, policy development or approval, etc.

2. Frequency and Documentation of Board Meetings:

- a. Review minutes of the governing board or advisory board meetings for the last six months to confirm:

.Frequency of meetings

.Attendance

.Role of the board in program management. Document examples of board actions which indicate that the board participate in major agency decisions such as budget preparation, policy development and approval, and approval of unbudgeted expenditures.

- b. For each meeting, note whether at least two-thirds of board membership was in attendance.

3. Presence and Role of Advisory Board and Documentation of  
Advisory Board Meetings:

To determine that a community-based, government-administered agency has an advisory board and to assess what role it plays in guiding and advising the program, conduct the same steps as in IE 1 and 2.

F. FACILITIES:

Summary of Requirements:

Program facilities are to be licensed under Montana Administrative Code, Chapter 22, Section 16-2.22(1)-S2210, by the Department of Health and Environmental Sciences. Facilities are to be well-maintained and free from obvious hazards such as broken windows and stair cases. Facilities should provide adequate space for staff and client treatment activities. Alcohol programs are to have liability insurance of at least \$300,000 on their total operations, including client transportation.

Evaluation Procedures:

1. Licensure:

To determine the program's compliance with licensure requirements, observe whether the program has a current DHES license. If not, review the DHES inspection documents and note the reasons that a license was not granted.

2. Adequacy of Facilities:

To determine whether facilities provide adequate space, are

well-maintained and generally safe, perform the following steps:

.Conduct a tour of the treatment facility to observe general maintenance, utilization of space, and security of client files, equipment and drugs.

.Interview 3-5 professional staff to determine whether, in their judgment, space for client reception and interviewing is adequate. (See the "Professional Staff Interview Questionnaire," Exhibit II-2, in the Personnel Management and Staff Development Evaluation Guide.)

3. Insurance Coverage:

To determine whether alcohol programs are insured as required, observe the existence of a liability insurance policy of at least \$300,000 on the total operation, including client transportation.

## SECTION II

### PERSONNEL MANAGEMENT AND STAFF DEVELOPMENT EVALUATION GUIDE

## II.

### PERSONNEL MANAGEMENT AND STAFF DEVELOPMENT EVALUATION GUIDE

#### A. INTRODUCTION:

Evaluation of the personnel and staff development system includes interviews with staff, review of personnel files and review of inter-agency agreements and contracts. The evaluation areas are:

- job descriptions, staff certification
- personnel files and staff performance evaluation
- staff development
- use of volunteers
- turnover, vacancies and staff availability
- subcontracts and service agreements

The review should begin with an interview with the staff member(s) responsible for personnel policies, staff development and development of inter-agency service agreements. During initial interviews, the following areas should be included:

- Determine the approximate number of professional staff "certified" by the Department of Institutions.
- Determine how personnel files are organized including location and content.
- Determine the nature of the program's staff development plans and activities.
- Determine whether volunteers are being used.
- Determine the number of agencies with which the program has developed agreements or contracts for provision of services to program clients.

During this interview, the evaluator should explain the purpose and methods of the personnel and staff development review. Following the interview, the evaluator should perform the following evaluation procedures.

NOTE: If copies of written program policies, procedures and plans are not centrally located, additional evaluation procedures may be required. (See the Organization and Program Management Review Guide.)

B. JOB DESCRIPTIONS AND STAFF CERTIFICATION:

Summary of Requirements:

For all mental health, drug abuse treatment and alcoholism treatment staff positions:

- .Job descriptions, including required staff qualifications must be prepared.
- .A position classification system must be developed which differentiates between levels of responsibility and complexity of work.
- .For professional positions, personnel must meet the Department of Institutions certification standards and be appropriately certified.

Evaluation Procedures:

1. Development of Written Job Descriptions and Staff Qualifications:

To assess whether the program systematically develops required qualifications for and descriptions of each staff position, interview the personnel director and perform the following steps:

- a. Describe the procedures used to hire new personnel including:

- .Application for employment
- .Persons responsible for selecting new employees
- .Position classification and qualifications
- .Job descriptions

- b. Briefly review resumes of newly hired personnel to assess



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To assess whether the program systematically develops required qualifications for and descriptions of each staff position, interview the personnel director and perform the following steps:

a. Describe the procedures used to hire new personnel including:

.Application for employment

.Persons responsible for selecting new employees

.Position classification and qualifications

.Job descriptions

b. Briefly review resumes of newly hired personnel to assess

whether education and/or experience meets qualification standards.

- c. From the organization chart, select every third position and observe a written copy of the job description for that position. Document results. Keep a record of these positions for further testing in the following evaluation procedures.

## 2. Professional Staff Certification:

To determine whether professional staff are certified as required, observe the certification document issued by the Department of Institutions for all professional staff selected in the above sample of staff positions. Document the number and percent of those positions for which staff are certified. For those not certified, has an application for certification been sent to the department?

## C. PERSONNEL FILES AND STAFF PERFORMANCE EVALUATION:

### Summary of Requirements:

For all mental health, drug abuse treatment and alcoholism treatment programs, a personnel file is to be maintained for each employee. Further, a system should be implemented for staff performance evaluation at least annually. While not required, content of personnel files should include at a minimum:

- .Employee resume and job application
- .Compensation amount including historical documentation for increases
- .Results of performance evaluation
- .W-4 form
- .For terminated employees, reasons for termination.
- .Job description

## Evaluation Procedures:

### 1. Implementation of Personnel Files and Staff Performance

#### Evaluation:

To determine the existence and content of personnel files and whether staff performance evaluations are routinely conducted, interview the personnel director and obtain access to personnel files and perform the following steps:

- a. Describe the program's procedure for conducting staff performance evaluations including:

- .Frequency

- .Content and forms used (obtain a copy)

- .Personnel responsible for conducting staff performance evaluation

- .Is the agency director's performance annually evaluated by the governing board?

NOTE: Not applicable to government agencies.

- b. For the employees selected in the above sample of staff positions, obtain and review each personnel file (include the program director) and complete the "Personnel File Documentation Worksheet" Exhibit II-1. Also, obtain the personnel file(s) for recently terminated employees and

PROGRAM NAME \_\_\_\_\_  
REVIEWED BY \_\_\_\_\_  
DATE: \_\_\_\_\_

PERSONNEL FILE DOCUMENTATION WORKSHEET

EMPLOYEE NAME	PERSONNEL FILE AVAILABLE (R)	JOB APPLICATION	EMPLOYEE RESUME	CURRENT COMPENSATION AMOUNT	RESULTS OF PERFORMANCE EVALUATION (R)	W-4 FORM	FOR TERMINATED EMPLOYEES-- REASON DOCUMENTED?
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Number of files missing documentation							
Percent of files reviewed missing documentation							

determine whether the reason for termination is documented in the file. Enter results on the "Personnel File Documentation Worksheet."

D. STAFF DEVELOPMENT:

Summary of Requirements:

All mental health, drug abuse treatment and alcoholism treatment programs must provide regular staff training consistent with the annual training plan (see organization and Program Management Guide on required policies, procedures and plans).

For mental health programs, not less than three in-service training seminars are to be held annually for all professional staff. In addition, each professional staff member must have an opportunity to attend at least one external conference or workshop annually.

Evaluation Procedures: .

1. Implementation of Annual Program Training Plan:

To determine whether the annual program training plan is actually implemented and to assess the nature of program staff development efforts, interview the individual responsible for training plan implementation and perform the following steps:

NOTE: If there is no one individual responsible for training plan implementation, this is a weakness and should be documented.

- a. Describe the training programs conducted during the past 12 months. Compare these programs with those listed in the annual training plan. Based on this comparison, does it appear that the training plan was implemented?

- b. Obtain files indicating training content and attendance of training programs and document the following:

.Approximately what percent of the then current professional staff attended each training program?

.Were written outlines and training materials developed indicating a well planned training activity?

- c. Describe the system for training new employees. Has the program developed staff orientation materials for all new employees such as a staff handbook?

- d. To validate the existence of orientation and on-going training, interview 3-5 staff members and determine the following: (See the "Professional Staff Interview Questionnaire," Exhibit II-2.)

.Did all staff interviewed participate in orientation training?

.Did professional staff have adequate notice and opportunity to attend on-going training? Did professional staff attend training programs provided during the last 12 months?

.For mental health programs, did professional staff have an opportunity to attend three in-service

training seminars or workshops and one external training program during the last 12 months?

E. USE OF VOLUNTEERS:

Summary of Requirements:

For all mental health, drug abuse treatment and alcoholism treatment programs, volunteer selection and evaluation criteria should be written and distributed to volunteers. Volunteers should be trained for their assignments and supervised by full-time professional staff. And finally, (while not a requirement), records should be kept of hours spent by each volunteer.

NOTE: Record keeping of hours contributed by volunteers is a requirement for those programs using volunteers as in-kind contributions for matching purposes.

Evaluation Procedures:

1. Use of Volunteers:

To assess the extent to which volunteers are used and the adequacy of their training and supervision interview the individual responsible for volunteer selection and monitoring and perform the following steps:

- a. Describe the services rendered by volunteers.
  - b. Obtain and review documentation describing volunteer selection and evaluation criteria for each service which is provided by volunteer staff.
  - c. Describe the volunteer training procedures used including description of printed materials distributed to volunteers.
- Does it appear that volunteer training is well planned?



d. Interview 3-5 volunteers and determine the following:

-In the volunteer's opinion, did each volunteer receive adequate training for his/her assignments?

-Does the volunteer have adequate resources, supervision and easy access to professional staff for consultation?

-What methods are used for recording of daily hours contributed by the volunteer?

2. Record Keeping for Staff Hours Contributed by Volunteers:

To assess the adequacy of record keeping for contributed staff hours by volunteers especially for those programs using volunteers as "in-kind match" for state or federal matching requirements, interview the appropriate administrative staff and determine the following:

a. Are volunteers used for in-kind matching purposes?

b. Describe the system for reporting and recording of contributed volunteer hours. Is the system easy to follow and is there appropriate supporting documentation for hours spent during the most recent month? For three volunteers, trace the reported hours spent during the

- × most recent month back to time cards or logs maintained by volunteers.

F. TURN OVER RATE, VACANCIES AND STAFF AVAILABILITY:

Summary of Requirements:

For all mental health, drug abuse treatment and alcoholism treatment programs, professional staff time should be available to the extent of caseload demand. This means that client-requests for services should be met on a timely basis indicated by minimum needs for "waiting lists"; and professional staff ability to provide services requested by their current caseload. Other indicators of possible lack of staff availability are 6 month turn over rates of more than 20-30% and excessive delays (more than two months) in filling vacant professional staff positions.

Evaluation Procedures:

1. Waiting Lists and Professional Staff Availability:

For this procedure and all following related procedures, the evaluator should attempt to gain an overall impression of whether or not there is a major program problem with staff availability to clients. These procedures are not intended to obtain "absolute" determination of the lack of staff availability due to the subjective nature of the evaluation area. Rather, by performing the following steps, insights should be available for discussion with the program director about possible corrective actions to improve overall staff availability if necessary. In order to gain these insights, perform the following steps.

- a. Interview the program receptionist or other appropriate clerical personnel and determine the following:

.Are waiting lists used? If yes, how many clients are on the list waiting for assignment to a professional for intake or counseling activities?

.In the receptionist's opinion, is it routinely difficult to find a professional available for assignment of new clients or one-time requests for services?

- b. Interview 3-5 professional staff representing each service program available (residential, outpatient, partial hospitalization, etc.) and determine the following: (See the "Professional Staff Interview Questionnaire," Exhibit II-2.)

.Do staff believe they are generally available to meet client-requests for services?

.If no, determine the reason and document results. Compare findings with documented client census data. (See the client treatment and census review guide.)

NOTE: The evaluator should be cautious in assessing the reasons given and

determine if the problem relates to a general excessive caseload or poor counselor assignment practices.)

2. Turn Over Rate:

To determine the approximate turn over rate for professional treatment staff (as opposed to clerical or purely administrative) obtain from the personnel director the present number of professional treatment staff and the number terminated during the past six months. Compute the six month turn over rate as follows:

$$\frac{\text{Number of professional staff terminations in the last six months}}{\text{Number of current professional staff}} \times 100 = \frac{\quad}{\quad} \%$$

3. Vacancies:

To assess the extent to which program management aggressively pursues filling vacant professional positions, interview the personnel director and review the program personnel budget and personnel or payroll records to determine the following:

- a. How many budgeted professional treatment positions are currently vacant? List each position including budgeted salary and required education or experience.

- b. For each vacant position, determine the length of time the position has been vacant.
- c. For those vacant over two months, determine the reason and describe the personnel director's procedures for filling vacant positions. Does the problem appear to be related to the lack of available qualified personnel or to general weaknesses in the timeliness or regularity of pursuing new employees?

4. General Assessment:

At the conclusion of all the above staff availability evaluation procedures, the evaluator should make a general assessment about the reasonableness of present staffing levels considering the following areas:

.Does the program appear to be over budgeted for personnel costs considering the actual number of filled versus vacant positions?

.Does the documented caseload support the need for current budgeted staff positions? (See Client Treatment and Census Review Guide.)

## EXHIBIT II-2

PROFESSIONAL STAFF INTERVIEW QUESTIONNAIRE

The questions below are to be asked of 3 to 5 staff members representing all service programs available (residential, outpatient, partial hospitalization, etc.). The purpose of the questionnaire is to verify with staff that program requirements for selected areas have been implemented. Prior to conducting the staff interview, the evaluator should meet with other members of the evaluation team to obtain the necessary background information indicated by each question.

<p><u>I. ORGANIZATION AND PROGRAM MANAGEMENT</u></p> <p>A. Organization Structure</p> <p>1. Does the present organization chart accurately reflect lines of authority and reporting relationships?</p>	<p>YES _____ NO _____</p>
<p>2. Are the program director and supervisors available to staff for problem solving and direction?</p>	<p>YES _____ NO _____</p>
<p>3. Do staff believe the organization structure makes sense and do they believe that they have been given adequate instruction and authority to perform assigned functions?</p>	<p>YES _____ NO _____</p>
<p>4. Who in the organization is responsible for supervision of the following functions: (A single individual should be assigned for each function.)</p> <p>--Personnel --Training --Accounting --Client Treatment</p>	<p>_____ _____ _____ _____</p>

<p>B. Goals, Objectives, and Program Self-Evaluation</p> <p>1. Are staff aware of current program goals and objectives? Do they believe, based upon directions they have received, that the written statement of goals and objectives accurately reflects current goals and objectives?</p>	<p>YES _____ NO _____</p>
<p>C. Facilities</p> <p>1. In the judgment of staff, is space for client reception and interviewing adequate?</p>	<p>YES _____ NO _____</p>
<p>II. <u>PERSONNEL MANAGEMENT AND STAFF DEVELOPMENT</u></p>	
<p>A. Staff Development</p> <p>1. Did all staff interviewed participate in orientation training?</p>	<p>YES _____ NO _____</p>
<p>2. Did professional staff have adequate notice and opportunity to attend ongoing training? Did professional staff attend training programs provided during the last twelve months?</p>	<p>YES _____ NO _____</p>
<p>3. (For mental health programs) Did professional staff have an opportunity to attend three in-service training seminars or workshops and one external training program during the last twelve months?</p>	<p>YES _____ NO _____</p>
<p>B. Turnover Rate, Vacancies and Staff Availability</p> <p>1. Do staff believe they are generally available to meet client requests for service?</p>	<p>YES _____ NO _____</p>

III. CLIENT TREATMENT AND CENSUS

A. Client Census and Reporting

1. Are program reporting and recording  
procedures understood by staff?

YES \_\_\_\_\_ NO \_\_\_\_\_

NOTE: Explain All NO Answers



G. SUB-CONTRACTS AND SERVICE AGREEMENTS:

Summary of Requirements:

For mental health, drug abuse treatment and alcoholism treatment programs, agreements or contracts with other service agencies providing services for which the agency pays should, at a minimum, include:

- .Description of services
- .Basis for payment including number of clients to be served and total amount of the contract
- .Duration of the contract
- .Appropriate signatures of the program director and a representative of the board of directors

Evaluation Procedures:

1. Existence and Content of Service Agreements and Contracts:

To assess the existence and nature of service agreements, interview the program director and obtain copies of contracts or agreements for services for which the agency pays. Determine the following:

- a. What services are provided under agreement or contract and by what agencies? At what cost?
- b. Are written contracts or service agreements developed for each? Do they contain the suggested content? Document results.
- c. Does the agency document services actually received under contract? Are there attachments to invoices which indicate what services were provided?



### SECTION III

#### FINANCIAL MANAGEMENT EVALUATION GUIDE



### III.

#### FINANCIAL MANAGEMENT EVALUATION GUIDE

##### A. INTRODUCTION:

Review of the financial management practices of mental health, drug abuse treatment and alcohol treatment programs includes interviews with the program director and the chief fiscal officer, documentation of total expenditures and revenue for the present program year and the past three program years, and assessment of internal financial controls used by the program. This assessment will involve detailed review of the programs internal accounting system and as a result requires the skills of a trained and experienced individual in financial accounting. The review areas include:

- Current, historical and future financial condition.

- Budgeting performance and cash management.

- Review of internal controls including:

- .General accounting issues
- .Payroll and personnel
- .Procurement and payments
- .Supplies inventory
- .Revenue sources, billing and collections
- .Petty cash and cash on hand
- .Pre-paid expenses and other current assets
- .Property plant and procurement
- .Notes payable and long term debt

If the fiscal system is maintained by an agency of county or state government, the review of internal controls will not be conducted.

The review should begin with an interview of the program's chief fiscal officer. The objectives of the initial interview are to:

- Identify other fiscal personnel to be interviewed.

- Identify sources of program funds by type and funding period.

- Determine location and content of a fiscal policy manual or procedures.

- Determine whether the program is receiving timely reimbursement from federal, state and local funding sources.

- Determine whether the program charges clients for services rendered and the extent of program's use of third party payment sources.

- Determine whether annual financial audits are conducted by a certified public accountant.

During this interview the fiscal officer should be told of the purpose of the review and of the need to assess fiscal records. If appropriate, a fiscal or clerical employee should be identified to assist the evaluator in locating pertinent files. Following the interview with the chief fiscal officer, the appropriate fiscal personnel identified by the fiscal officer should be interviewed to provide the evaluator with an understanding of fiscal procedures and to identify the location of verification materials for performance of the following evaluation procedures.

B. CURRENT, HISTORICAL AND FUTURE FINANCIAL CONDITIONS:

Objectives of Review:

The objectives of this section of the evaluation are to evaluate and develop conclusions regarding the program's long-range financial planning strategies for ensuring the survival and continuity of the program. This will be accomplished in part by evaluating the historical and current program financial condition.

Evaluation Procedures:

1. General Financial Planning Resources and Activities:

To assess the program's general approach to financial planning, interview the program director and/or the chief fiscal officer and determine the following:

- a. Who is responsible for financial planning?
- b. What reports are prepared by the accounting department and how frequently?
- c. What are the major sources of income and expenditures for the program? (See the "Estimated Income and Expense Worksheet," Exhibit III-1.)

## EXHIBIT III-1

Program XYZEstimated Income and Expense Worksheet

	<u>LAST THREE YEARS</u>			<u>ANNUALIZED CURRENT YEAR</u>
	<u>1</u>	<u>2</u>	<u>3</u>	
<u>INCOME</u>				
State (List)	\$ _____	\$ _____	\$ _____	\$ _____
Federal (List)	_____	_____	_____	_____
Third Party (List)	_____	_____	_____	_____
Client Fees	_____	_____	_____	_____
Food Stamps	_____	_____	_____	_____
Local Government (List)	_____	_____	_____	_____
Other (List)	_____	_____	_____	_____
TOTAL	\$ _____	\$ _____	\$ _____	\$ _____
<u>EXPENSE</u>				
Salaries & Fringes	\$ _____	\$ _____	\$ _____	\$ _____
Other Direct Expenses <sup>1</sup>	_____	_____	_____	_____
Subcontractor Services (If Applicable List Each)	_____	_____	_____	_____
TOTAL	\$ _____	\$ _____	\$ _____	\$ _____
Excess of Income Over Expenses (If Applicable)	\$ _____	\$ _____	\$ _____	\$ _____
Excess of Expenses Over Income (If Applicable)	\$ _____	\$ _____	\$ _____	\$ _____

NOTE: This data is intended to assist in a management assessment of overall financial condition. It is not intended to take the place of an audited financial statement. Therefore, the evaluator should rely where necessary on program provided data.

<sup>1</sup> \_\_\_\_\_ Includes food, supplies, rent, travel, etc.

- d. Has the program identified any funding source to substantially supplement federal or state funding?
- e. Has the program enacted a client fee system and a third party payment collection system?

Health services funding regulations (42 CFR Part 50, Subpart A) require that programs receiving federal funds submit a three year plan for third party payments. Review this plan against the programs' actual third party experience and comment if appropriate.

- f. Has the program considered the following sources of third party funding?

Title XX

Medicaid

Blue Cross/Blue Shield

Other Private Insurance

Champus

Other

- g. If the program has not considered any of the above third party sources, probe regarding why not.
- h. If they have considered these third party sources but not actively pursued them, probe regarding reasons.



## 2. Current, Historical Financial Condition

To evaluate and draw conclusions regarding current and historical financial condition of the program, obtain the assistance of the chief fiscal officer and review present and past revenue and expenditure documentation and perform the following steps:

- a. Develop a three year trend analysis of the program's income and expenditures (if possible). Document results on "Estimated Income and Expense Worksheet," Exhibit III-1.
- b. Evaluate and understand any major changes in the income and expenditures.
- c. Discuss with program management the expected financial condition of the program one or two years from now. Develop an understanding with them on how they will adjust their program if any major changes are expected in increased expenditure requirements such as needed capital items or reduced revenues such as conclusion of federal grants or contracts.
- d. Subsequent to reviewing the initial results of the overall program evaluation, discuss with management where long range cost savings or increased revenue might be

realized and the potential impact on the program. Some areas to consider would be:

.Personnel savings.

.Increases in client fees or third party collections.

.Increased efficiency in use of community support services provided at no cost to the program.

C. BUDGETING PERFORMANCE AND CASH MANAGEMENT:

Objectives of Review:

The objectives of this section of the evaluation are to review the program's budgeting procedures and evaluate how actual program expenditures and revenue compare with those budgeted, and to develop conclusions regarding the nature of any major variances. A second objective is to evaluate how cash requirements are developed and met, and how surpluses or deficits are managed and to draw conclusions about this process.

Evaluation Procedures:

1. Current Budgeting Performance:

To assess current budgeting performance and methods, interview the chief fiscal officer and perform the following steps:

a. Obtain a copy of the budget for the current fiscal year.

Determine that the budget:

.Includes line items for all the accounts which will actually be used during the year.

.Is consistent with the line item distribution presented on the budget submitted to the Department of Institutions.

- b. Have there been any revisions in the line item budgets?  
If yes, document the procedures for these revisions.
- c. Develop a comparison of the program's budgeted versus actual expenditures (6 or more most recent months if possible).  
Complete the "Budget versus Actual Expenditure Worksheet",  
Exhibit III-2.
- d. Obtain an explanation for any major budget overruns during the last six or more months and management steps taken to remedy these budget overruns.

2. Cash Management:

To evaluate how cash requirements are developed and met, and how surpluses or deficits are managed, and to draw conclusions about this process, interview the chief fiscal officer and determine the following:

- a. Who is responsible for budgeting requirements?

EXHIBIT III-2

Program XYZ

Budget Versus Actual Expenditures

(X Number of Months Ended \_\_\_\_\_, 197\_\_)

	<u>BUDGET</u>	<u>ACTUAL</u>	<u>VARIANCE</u>
<u>INCOME</u>			
State (List)	\$ _____	\$ _____	\$ _____
Federal (List)	_____	_____	_____
Third Party (List)	_____	_____	_____
Client Fees	_____	_____	_____
Food Stamps	_____	_____	_____
State (List)	_____	_____	_____
Local Government (List)	_____	_____	_____
Other (List)	_____	_____	_____
TOTAL	\$ _____	\$ _____	\$ _____
<u>EXPENDITURES</u>			
Salaries & Fringes	\$ _____	\$ _____	\$ _____
Other Direct Expenses <sup>1</sup>	_____	_____	_____
Subcontractor Services	_____	_____	_____
(If Applicable List Each)	_____	_____	_____
TOTAL	\$ _____	\$ _____	\$ _____
Excess of Income Over Expenses (If Applicable)	\$ _____	\$ _____	\$ _____
Excess of Expenses Over Income (If Applicable)	\$ _____	\$ _____	\$ _____

NOTE: This data is intended to assist in a management assessment of overall budget performance. It is not intended to take the place of an audited financial statement. Therefore, the evaluator should rely where necessary on program supplied data.

<sup>1</sup> Includes food, supplies, rent, travel, etc.

- b. How soon before the beginning of the fiscal year is the budget prepared?
- c. How are estimates done? Is the process formal and documented?
- d. What happens when a delay or curtailment occurs in receiving revenue from a particular funding source?
- e. How does the program finance its current expenses in this situation? (Probe)
- f. Does the program accelerate its draw down of federal or state funds when necessary?
- g. Does the program utilize (or plan to utilize) its unobligated federal or state balances (if any) for these purposes?
- h. Has the program developed a surplus for working capital?
- i. For mental health programs, perform the following steps to ensure that available non-state funds are spent prior to state funds, and that cash reserve accounts do not exceed 17% of a mental health center's total annual budget:

.To ensure that "available" cash reserve accounts do not exceed 17% of a mental health center's total annual budget:

-Obtain the Department of Institutions' "Definition of Funds Not Available" policy memorandum dated August 3, 1976. Determine how the CMHC has defined its "available" and "non-available" cash accounts, i.e., operating cash, endowment funds, capital reserves, cash reserves, etc. A governing board resolution supporting the definitions should be obtained and reviewed. The definitions should be in compliance with the "Definition of Funds Not Available" memorandum issued by the Department of Institutions.

-Obtain a total-center balance sheet (preferably from audited financial statements) for the most recent fiscal year-end. Divide the total amount shown for "available cash reserve" accounts by the total amount of operating expenses budgeted for the current fiscal year. If this ratio exceeds 17%, the CMHC is not in compliance.

.To ensure that "available" funds other than state

general fund monies are spent prior to state general fund monies:

-Review the total center budget for the current fiscal year. If budgeted income is greater than budgeted expenses, determine from the fiscal officer the reason for the excess, and whether that excess will be placed in a "non-available" cash account.

NOTE: If the excess is to be "available", the center is a priori out of compliance, and the state grant should be correspondingly reduced.

-Review actual income and expenses for the current fiscal year-to-date versus the budgeted year-to-date.

--If actual expenses are under budget, determine whether claims or receipts of state grant funds are under budget by the same amount (see the state grant income line item). If they are not, state general funds are not being spent last.

--If actual income in any category other than state grant income is greater than budget and is not matched by corresponding actual expense increases, determine whether the excess income is placed in an "available" cash account, If it is, then determine whether claims or receipts of state grant funds are under budget by the same amount. If they are not, state general funds are not being spent last.

D. IMPLEMENTATION OF INTERNAL FINANCIAL CONTROLS:

For the following evaluation procedures, the evaluator should work closely with the chief fiscal officer and his staff to complete the evaluation steps. In the first section (determination of the system of internal control), the evaluator should interview the chief fiscal officer and complete the "Internal Financial Controls Questionnaire", Exhibit III-3.



## QUESTIONNAIRE



4. Miscellaneous:

[illegible]

-Payroll and Personnel:

Review Objective:

To determine if adequate procedures exist to properly process payroll given the size and complexity of the organization.

**Ideal Conditions:**

New employees are investigated before being hired. Wage and personnel policies are current in writing. Current and complete personnel files are maintained. An adequate system is used to insure proper recording of hours and time, e.g., weekly time reports are being used for all employees. All salary and wage payments are made by checks which are signed and distributed by persons other than those preparing the payroll or controlling hiring and termination. All payroll computations are independently double checked. The payroll bank account is reconciled by someone other than the person preparing the payroll or signing the checks.

	EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
		N/A	YES	NO
1. <u>Personnel, Employment and Rate Authorizations:</u>				
a. An appropriate official authorizes:				
1) Initial rates of pay.				
2) Any subsequent changes in rates of pay or position.				
2. <u>Payroll Preparation and Time Keeping:</u>				
a. Time keeping and time cards:				
1) Time keeping is separated from payroll preparation.				
2) Formal attendance records are used, e.g., time clock cards, weekly time reports, etc.				
3) Time keepers use face check sheets or similar methods to check attendance where there are no time clocks.				
4) Where time clock cards are in use, controls exist to prevent one person from punching more than one time card.				
5) Approval of department head on time cards or other attendance data is required prior to preparing payroll.				
6) Changes on time cards must be initialed/approved by a department head or similar person.				
b. Persons preparing the payroll do not perform other payroll duties (e.g., time keeping, distribution of checks) or have access to other payroll data or cash.				





- e. Adequate physical and accounting controls exist over blank checks while in EDP area.
7. Reconciliation of Payroll Bank Accounts and General:
- a. Payroll bank accounts are reconciled by employees who have no other payroll functions.
  - b. Reconciliation procedures include all procedures specified for reconciliation of normal commercial disbursing accounts.
  - c. Salary and special payrolls are subject to the same critical review as regular payroll.
  - d. Hourly payrolls are compared as between periods and adequate explanation is required for significant variances.
  - e. The payroll distribution entry is prepared by someone having no responsibility for payroll preparation, or preparation or distribution of payroll envelopes or checks.
  - f. If pension costs and/or vacation accruals are involved, there are controls to assure adequate segregation of payroll costs applicable to the computations of those amounts, including control over eligible employees and changes in qualifications and rates.

EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
	N/A	YES	NO

-Procurement and Payments:

Review Objective:

To review and develop conclusions about the programs overall purchasing and cash disbursements functions.

Ideal Conditions:

Purchasing and Accounts Payable:

All significant purchases must be supported by an approved purchase order. Where warranted, dollar limitations on purchases without officer or board approval are printed on the face of the purchase order form. Major vendors should be advised of purchasing requirements and policies. Competitive bids are required on purchases over a specified amount. Numerical and physical control is maintained over unissued purchase order stock. Purchase orders are used in numerical sequence. The purchasing system is designed to insure accurate and prompt recording of purchases, payables and the taking of all discounts. Copies of purchase orders are sent as issued to receiving and accounting. Purchasing personnel are not involved in receiving, payables, disbursing or other conflicting functions. Vendors' invoices are checked to purchase orders and receiving reports and clerical accuracy is proven before approval for payment. Vendors' statements are checked to recorded liabilities regularly by independent personnel.

Cash Disbursements:

Prenumbered voucher checks are used on all disbursements. Numerical and physical control is maintained over blank as well as issued checks. Authorized signatures are approved by the Board of Directors and are periodically reviewed and updated. Counter signatures are required on all checks over a specified amount. A check protector is used and check signing machines and facsimile signature plates are properly controlled. All supporting documents are presented to authorized signers along with check for signature and are cancelled at the time of signature. Checks are adequately safeguarded before mailing and are mailed by someone independent of disbursing. Voided or spoiled checks are adequately mutilated and are retained on file in sequence. Disbursing personnel are not involved in receiving, purchasing, or receipts.

1. Purchasing:

- a. Purchase orders are used on all purchases and they show vendor, date price, quantity and delivery terms, method, date and destination.
- b. Purchasing function is performed by and purchase orders are prepared by personnel independent of:
  - 1) Receiving and shipping functions.
  - 2) Payables and disbursing functions.

EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
	N/A	YES	NO



- c. Special limitations exist on and approvals are required for:
    - 1) Purchases for or from employees.
    - 2) Purchases of equipment.
    - 3) Purchases of goods delivered directly to clients.
  - d. A current and adequate manual of purchasing procedures exists. (The reviewer should review it in conjunction with internal control in this area.)
  - e. Copies of purchase orders are distributed to:
    - 1) Vendor
    - 2) Purchasing department historical vendor files.
    - 3) Accounting.
    - 4) Receiving.
    - 5) Others (List) \_\_\_\_\_
  - f. Purchase orders are:
    - 1) Prenumbered and used in sequence.
    - 2) Initiated on the basis of purchase requisitions approved by a responsible employee.
    - 3) Limited to purchases less than \$\_\_\_\_\_ on their face without prior approval by an officer or the Board of Directors.
    - 4) Prior to mailing, approved by a responsible employee not associated with receiving, payables or disbursements.
  - g. Numerical sequence is checked by an employee independent of initiation of purchases.
2. Accounts Payable:
- a. Vendors invoices and all copies are:
    - 1) Routed directly to accounting from mail room.
    - 2) Stamped so that all copies are clearly marked "DUPLICATE".
  - b. Original vendors invoices are:
    - 1) Vouchered and listed/recorded in a voucher/purchases register immediately on receipt.
    - 2) Maintained in the accounting department and only copies are distributed when required.

	EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
		N/A	YES	NO
c. Vouchers prenumbered and numerical sequence is periodically checked by an employee independent of voucher preparation.				
d. In processing the invoice and related voucher:				
1) All data thereon is checked to approved copies of the purchase order and receiving report.				
2) All extensions, footings, discounts and freight terms are checked for accuracy as required by program policy.				
3) The performance of 1) and 2) is clearly indicated on the face of the invoice.				
4) A responsible employee reviews and approves the invoice account distribution and approves for payment.				
5) The total of unprocessed vendors invoices and vouchered and unpaid items is determined and reconciled to voucher/purchases register and accounts payable detail at month end by someone independent of the detail posting function.				
e. Vendors' month end statements:				
1) Are reconciled periodically by an employee independent of voucher preparation to recorded liabilities based upon invoices accrued.				
2) Are marked "statement" to prevent payment if the program pays on an invoice basis.				
3) Are reviewed for non-current invoice dates.				
f. If advance payments are made to vendors:				
1) They are regularly approved prior to payment.				
2) They are set up as accounts receivable or equivalent.				
g. A record is kept on all recurring payments to prevent duplicate or skipped payments, e.g., rent, insurance, debt, etc.				
h. Personnel performing the payables function are not involved in the purchasing, receiving, disbursing inventory and general ledger functions.				
3. <u>Cash Disbursements:</u>				
a. <u>Check Stocks:</u>				
1) All disbursements are made by check.				
a) Are any expenditures over \$100 made in cash?				
2) Checks are printed on protected paper.				

	EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
		N/A	YES	NO
4) Checks are prenumbered and used in sequence.				
4) Physical and accounting controls over unauthorized use of blank check stock are adequate.				
5) There is a specified custodian for blank check stocks.				
<b>b. <u>Check Preparation:</u></b>				
1) Checks are prepared by specified employees who are independent of voucher approval.				
2) Employees preparing checks compare all data on voucher and support checks.				
3) All checks, disbursement vouchers or check requests are approved for payment by the check signer or other responsible employee.				
4) Checks are recorded in disbursements book as prepared.				
5) Checks are made payable to specified payees and never to cash or bearer.				
6) A check protector is used.				
7) Voided/spoiled checks are properly mutilated and retained.				
8) All support accompanies check when presented for signature.				
9) All supporting documents are properly cancelled at time of signature to prevent duplicate payment.				
<b>c. <u>Check Signing:</u></b>				
1) Check signers are authorized by the Board of Directors.				
2) Authorized signatures are independent of:				
a) Voucher preparation and approval for payment.				
b) Check preparation, cash receiving and petty cash.				
c) Purchasing and receiving.				
3) All checks over \$_____ require two manual signatures.				
a) When countersigned, both signers review vouchers and supporting data and are independent of each other.				
4) Signing blank checks is forbidden.				

- d. Bank Reconciliations:

- NOTE: The lack of segregation of duties is a frequently observed problem because of program size. Temper the recommendations with the size of the program.

EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
	N/A	YES	NO

-Supplies Inventory:

Review Objective:

To review whether the organization has a system to monitor and safeguard their supplies.

**Ideal Conditions:**

A receiving function separate from custody of or access to the stock room is established which checks all goods on receipt. Controls exist over receipts through the use of pre-numbered, numerically controlled receiving reports.

Complete physical inventories are taken at least once a year in accordance with sound written procedures adequately supervised. Physical counts are reconciled to perpetual records and general ledger controls which are adjusted as required. Where used, perpetual inventory records are maintained in balance with general ledger controls and are reviewed periodically for unusual inventory conditions, slow moving, overstocked items, etc.

Inventory usage and shipments are controlled by the use of prenumbered, numerically controlled stores requisitions, and shipping tags. Physical facilities for storage of inventory allow for efficient access to, use of, and physical control over inventory. Adequate controls exist for inventory stored in outside locations.

1. Receiving:

- a. Separate receiving function exists.
- b. Receiving verifies quantity and quality of materials on receipt.
- c. Formal receiving reports are utilized.
- d. Receiving documents are properly dispersed throughout the system.

2. Physical Inventory:

- a. All goods are physically inventoried at least annually.
- b. Physical inventories are supervised by a responsible employee.
- c. Written inventory taking procedures, determined by responsible officials exist.
- d. Perpetual inventory records are reconciled and adjusted at least once a year to physical inventory quantities and such differences are investigated by a responsible employee.

3. Protection of Inventory:

- a. There is adequate physical protection and insurance coverage on inventory.

EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
	N/A	YES	NO

- 1) All inventory is stored in assigned areas into which access is limited, particularly items of significant value susceptible to pilferage (such as high value small items).
- 2) Program premises are adequately surrounded by appropriate protective devices such as fences, guards, door or gate checks, etc.

EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
	N/A	YES	NO

-Revenue Sources, Billing and Collections:

### Review Objective:

To review and develop conclusions about the organizations systems for the receipt and recording of revenue.

Ideal Conditions:

Revenue, Billing and Accounts Receivable:

The program has identified sources of funds other than federal or state (social security, welfare, private insurers, etc.) and has instituted procedures to pursue these sources. There is adequate separation of duties between personnel in the billing and accounts receivable functions. Each entry into the billing and accounts receivable ledger is supported by adequate evidence. All non-cash credit entries such as allowances, bad debts, etc., are properly authorized. Subsidiary receivable ledger functions are performed by personnel having no access to incoming receipts or credit functions. Subsidiary ledgers are balanced and aged regularly.

Cash Receipts:

Cash receiving functions are handled by as few people as possible. Persons receiving cash have no access to accounting records. Incoming cash receipts are primarily in the form of checks and drafts and are deposited daily and intact. The receipt of cash is provable by other separately maintained records. Periodic reconciliations of detail cash receipt records to duplicate deposit slips, accounts receivable and cash control accounts, etc., are prepared by personnel independent of cash functions.

## 1. Federal Funds:

- a. The grant or contract has been signed for the current program fiscal year.
- b. The program has an indirect cost rate.
- c. The current grant or contract has been adjusted to reflect the unexpended balance from prior years.
- d. The program is drawing down federal funds at a uniform rate. If no, why?

## 2. Third Party Fees:

- a. An ongoing procedure exists for obtaining and updating information on third party coverage and eligibility status of project clients.
- b. The program maintains records on third party coverage and on the ability of patients to pay for services where applicable.
- c. Written agreements exist between the program and all third party payors or patients which specify the services to be provided and fees to be charged.

EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
	N/A	YES	NO

- d. Third party billings are based upon an estimate of actual program operating experience, e.g., the program has attempted to identify the actual costs of treatment for which it is billing. (Review and document their procedures.)
3. Client Fee System:
  - a. The program has enacted a client fee schedule.
  - b. The client fee schedule is based upon an estimate of actual program operating experience.
  - c. Are all services billed? Are they recorded as receivables? Are they attempting to collect these fees?
4. Local Money:
  - a. Formal, signed contracts are in effect.
  - b. The local funds have special restrictions. If so, what are they? (Probe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - c. The program has a separate accounting system for state and/or local funds.
  - d. The local funds are being received at a uniform rate. If not, probe. \_\_\_\_\_  
\_\_\_\_\_
  - e. The local funds are used as matching funds.
  - f. Do local contracts have cancellation provisions?
  - g. Are any of the local contracts scheduled to expire?
5. Non-Cash Revenue:
  - a. Does the program utilize non-cash items (such as food, furniture and volunteers) as matching funds for federal or state funds?
  - b. Is there any consistency to the receipt of non-cash revenue?
  - c. Are the receipt of these items documented?
  - d. Do they have a formalized system for assigning a monetary value to such things as used furniture, building space and volunteer time?
  - e. Are items which are claimed as match during the current fiscal year actually used in the operations of the program? Is such use formally documented?
6. Billing:
  - a. Written policies and procedures exist for billing of services.





	EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
		N/A	YES	NO
e. Adequate physical controls exist over cash receipts from time of mail opening until time of bank deposit.				
f. Cashing of checks out of daily receipts is forbidden.				
g. Post-dated checks, disputed items, unidentified receipts, NSF checks, checks charged back by banks, and similar items are subject to normal receipts control, and received and investigated by persons independent of preparation of deposits and posting of accounts receivable detail.				
h. Receipts of affiliate programs or remote sites are deposited locally and are subject to central program withdrawal.				
i. The general cashier function is segregated from the general ledger and subsidiary ledger functions.				
j. Persons receiving cash from over-the-counter and other sources are independent of other cash functions, custody of negotiable assets, posting of receivable detail and general ledger.				
l) Prenumbered receipts are issued for collections and duplicates are retained and controlled numerically.				
k. Adequate controls exist for collections made by program staff and others from patients, such as client fees and food stamps.				
l. Program's banks have been instructed not to cash checks payable to the program in special bank accounts, e.g., imprest payroll accounts.				
m. The Board of Directors authorized all bank accounts and check signers.				
10. <u>Letter of credit: (Direct transfer of money into organizations bank account.)</u>				
a. The program submits requests for payment on a timely basis.				
b. Is there a time lag in having fund transfers honored?				

-Petty Cash and Cash on Hand:

Review Objective:

To determine the size of the petty cash fund and review whether supporting documentation is maintained for withdrawal.

**Ideal Conditions:**

Petty cash funds are maintained on an imprest basis with one individual responsible for the fund. They are not commingled with other receipts. Responsibility for petty cash is separate from cash disbursing/receiving and receivable functions. Limits exist on amounts of any expenditure of or checks drawn on petty cash and on any unusual expenditure, e.g., wage and salary advances. Disbursements are evidenced by approved support prepared in ink on prenumbered forms. Support is checked and cancelled at the time the fund is reimbursed. Frequent and surprise counts of funds are made by internal audit or other independent personnel.

1. One employee, separate from custodianship of unrecorded cash, cash receiving and disbursing and accounts or notes receivable functions, has custodial responsibility for the fund.
  - a. Fund is maintained on an imprest basis in a reasonable amount.
2. Expenditure support is reviewed prior to reimbursement by a responsible official and is cancelled upon reimbursement to prevent reuse.
  - a. Reimbursements are made payable to the custodian.
3. Petty cash written policies cover limitation on amount of disbursement, approval requirements on cashing accommodation or personal checks, not allowing cashing of post-dated checks and placing restrictive endorsements on checks received.
4. No cash receipts from accounts receivable or other sources are commingled with petty cash funds.
5. Surprise counts and reconciliation of petty cash funds are periodically made by internal audit or other responsible employees.

EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
	N/A	YES	NO

-Property, Plant and Equipment:

**Ideal Conditions:**

Subsidiary records exist for fixed assets and depreciation reserves which are reconciled monthly to general ledger controls and are periodically compared to physical inventories of fixed assets. Specific policies on authorization for and control over acquisitions, transfers and sales or abandonments of program owned, leased and contractor/government owned/furnished assets. Approved depreciation and capitalization policies exist in writing and are adhered to by accounting.

	EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
		N/A	YES	NO
1. Detail records or subsidiary ledgers are maintained:				
a. By personnel independent of general ledger, cash, purchasing, payable, and fixed asset expenditure authorizing functions.				
b. On all fixed assets and depreciation (including fully depreciated, and government/contractor owned/furnished items).				
2. Actual payments are approved by Board of Directors, if over \$_____.				
3. Federal or State Funded Assets:				
a. Has the program acquired a substantial number of assets with federal or state funds?				
b. Are these assets properly tagged?				
c. Have physical improvements been made to program property?				
4. Real Estate:				
a. Any owned holdings? _____				
b. How acquired? _____				
c. Is property mortgaged? _____				
d. Is Board approval required?				
e. Identify which organization holds title to the property. _____				
5. Other Assets:				
a. Does the Board of Directors have sole authority for authorizing the purchase or sale of assets?				
b. Are maintenance logs for automobiles maintained?				
do procedures exist to prevent personal usage of organizational vehicles?				
d. Are reserves being established to ultimately replace equipment and vehicles?				
NOTE: Most programs have few physical assets except used furniture. Occasionally a program will own a building or transportation vehicles.				

-Notes Payable and Long-Term Debt:

**Ideal Conditions:**

Responsibility for authorization of long-term borrowings is vested with the Board of Directors or other management personnel. Two signatures are required on all loan agreements, evidences of indebtedness and repayment checks. Subsidiary records, periodically reconciled to general ledger controls, exist for all notes payable and long-term debt including related interest. Physical and accounting controls exist for all unissued, issued and cancelled notes and other certificates of indebtedness. Specified written procedures exist on all aspects of authorization, issuance, and redemption of notes and long-term debt and method and amount of paying interest.

1. Authorization for borrowings and execution of debt agreements and notes is vested with Board of Directors or other responsible management group personnel. Authorizations specifically state:
  - a. Name of officers empowered to borrow funds, maximum amounts such officers may borrow, and maximum terms of length of time allowable for such long-term debt.
  - b. Collateral which may be pledged to secure loans.
  - c. Allowable loan agreement restrictions or covenants.
2. Detail records on notes and other long-term liabilities are maintained by personnel independent of cash functions and are reconciled to general ledger controls periodically.
  - a. On repayment and receipt of paid notes, they are examined for proper endorsements and cancellation and are returned to and retained by an employee who does not maintain the detail records.
3. Notes, certificates, and other evidences of indebtedness are executed only in the program name and require the signature on such evidences, as well as on principal repayment checks of two officials who are authorized signers and are independent of each other.

EMPLOYEE PERFORMING PROCEDURE	PROCEDURE EMPLOYED		
	N/A	YES	NO

F. TEST OF TRANSACTIONS PROCEDURES:

General:

The objective of testing selected transactions is to both confirm the systems descriptions obtained in the prior section and develop a reasonable level of confidence in the cost figures. This is not an attempt to perform an audit.

The majority of program funds are generally attributable to personnel costs, and therefore the tests of payroll and personnel should take priority.

In any event, the level of effort and specific focus of the transaction testing should be determined after the programs overall system is understood. Listed below are indicators which should alert both the reviewer and team leader of a potential problem. The focus of the transaction testing should be adjusted as appropriate. These indicators are:

- .No audit for the most recently completed fiscal year.
- .The most recent audit contained a disclaimer.
- .The lack of staff continuity, particularly the controller (or his equivalent).
- .The excessive absence of the segregation of duties and functions in the accounting, financial and administrative areas.
- .The program is under current litigation.
- .Excessive delays in billing and reporting.
- .No books of original entry; e.g. general ledger, cash disbursements, cash receipts, and the payroll register.
- .Shortfall in cash.

-Purchasing, Accounts Payable and Cash Disbursements:

**Audit Objectives:**

The objective of test work in these areas is to ascertain that proper and timely recording, accrual, and accounting distribution occurs from the time an item is ordered through to when it is paid for and that the system is adequate to provide reasonable assurance against the perpetration and concealment of irregularities. To this end tests are set forth below on both source media and books of original entry in the areas of purchasing, vouchering and payables, cash disbursing and bank reconciliations. As far as possible, the selection of data for review should be representative of transactions found in the program's operation with emphasis on transactions effecting the primary operational areas.

TESTS PROCEDURES:

1. Purchasing - (Obtain the purchasing department purchase order (PO) file for the most recent completed reporting period and perform the following tests:)
  - a. Account for numerical sequence of purchase orders issued.
  - b. Review 5 purchase orders for propriety of:
    - 1) Completeness in accordance with program policy, including where applicable competitive bid supporting documents.

N/A	DONE	DATE

- 2) Clerical accuracy.
  - 3) Delivery location, method and terms.
  - 4) Approvals.
  - c. Trace these POs to the disbursement files and check to receiving reports, invoices and other support for reasonableness.
2. Voucher Register - (If the program maintains a voucher register or its equivalent, perform the following test for the most recent completed reporting period:)
- a. Test foot and crossfoot the voucher register for this period and trace postings to general ledger.
  - b. Select 10 vouchers.
    - 1) Compare to entries on voucher register.
    - 2) Compare information on voucher to supporting date, vendors invoices, receiving reports, purchase orders, subcontractor contracts, etc.
    - 3) Review voucher and supporting data for:
      - a) Evidence of invoice audit and approvals prior to payment.
      - b) Clerical accuracy on a test basis.
      - c) Propriety of account distribution (determining that unallowable costs are properly segregated from allowable costs under each program).
      - d) Approvals on receiving reports.
      - e) Propriety of prices, quantities, discounts and freight terms on invoices in relation to related purchase orders.
      - f) Evidence that all allowable discounts were taken.
      - g) Cancellation of supporting documents and voucher after payment.
      - h) Reasonableness of expenditure in relation to nature of operations.
    - 4) Trace vouchers to and compare them with entries in the cash disbursements with book and with paid checks, noting dates, payees, signatures, amounts and endorsements.
  - c. Account for numerical sequence of vouchers for the period.
3. Cash Disbursements
- If the program has a separate cash disbursing book/system obtain the disbursements book and perform these tests:
- a. Test foot and crossfoot the cash disbursements book and trace postings to the general ledger.
  - b. Compare 5 cancelled checks for the period with the disbursements book noting dates, payees, signatures, amounts and endorsements.

N/A	DONE	DATE

- c. Test the numerical sequence of checks during the period examining void or spoiled checks for proper cancellation. (If checks are still outstanding at the time of the test, trace them to the most current bank reconciliation.)
  - d. If the program maintains a voucher (accrual only) register, select the disbursement entries tested in b. above and trace them to entries in the voucher register and to the voucher and supporting data, reviewing such in the manner set for in 2.b.3) above, or  
  
If the program does not maintain a voucher register, select 10 disbursements for the period and perform steps:  
  
2.b.1) Compare check to disbursements book. . .  
2.b.2) Compare check to supporting data. . .  
2.b.3) Review supporting data. . .
4. Bank Reconciliations
- a. Review reconciliation for period noting timeliness and review by responsible official.
    - 1) Agree balances to general ledger.

N/A	DONE	DATE



## - Payroll and Personnel:

**Audit Objectives:**

The objectives of test procedures in this area are to ascertain that existing personnel policies are being followed, that the accounting procedures and system of internal control are adequate to provide for timely and accurate recording and distribution of labor costs and to provide reasonable assurance that payroll payments are not susceptible to the occurrence of irregularities. To this end, tests are set forth below of source media, books of original entry and subsidiary ledgers in the areas of personnel files, payroll payments, and labor distribution.

### TEST PROCEDURES:

1. Payroll Register

Obtain the register for the most recent pay period and perform the following tests:

- a. Trace or reconcile totals to the monthly payroll summary and check the clerical accuracy of the summary.
- b. Trace the monthly payroll totals to general ledger.
- c. Reconcile the monthly payroll total to the monthly payroll labor cost distribution.
  - 1) Trace labor Distribution totals to general ledger and current employee register.

## 2. Detail Employee Tests

Select four hourly and four salaried employees from the registers used in 1. above (See step 7.):

- a. Check hours worked to approved time cards, time sheets, etc. Review time cards for erasures, changes, and possible alterations not approved by the department head.
  - 1) Trace hours by operation or similar designation from time cards to the detail labor distribution for the period, checking calculations of amounts charged to the various operations or cost centers in conjunction with steps 2.b. and 2.c. below.
- b. Trace hourly or salary rate, including bonus, overtime, shift differential, travel time and vacation pay wherever applicable, to personnel file authorizations, approved salary lists.
- c. Examine supporting documents for payroll advances, per diem, and any other similar payment included in the pay check.
- d. Agree exemptions to signed copies of W-4 (See step 2.g. below).
- e. Check all calculations of gross pay, tax deductions and net pay.
- f. Trace all non-statutory deductions (retirement, savings bonds, credit union, etc.) to authorizations signed by the employee in personnel files or to other support and check any calculations included therein (for example, deduction amount for retirement fund contribution based on length of service).

[illegible]



-Revenue Sources, Billing, Accounts Receivable and Cash Receipts:

### Audit Objectives:

The objectives of test procedures in these areas are to ascertain that the accounting procedures and system of internal control are adequate to insure that when services are provided they are properly billed and recorded, that resulting receivables are properly stated and that appropriate cash collections are received and deposited. To this end, tests are set forth below of source media, books of original entry and subsidiary ledgers in the areas of billing, accounts receivables and cash receipts.

### TEST PROCEDURES:

## 1. Detail Invoice Tests

Obtain the third party or patient invoices for the test period, and

- a. Select 5 invoices issued in the test period from account department invoice files.
  - 1) Trace to supporting data such as patient records comparing services rendered vs. billed.
  - 2) Review for appropriate approvals, terms, and established fee in accordance with established program policies and fee schedules.
  - 3) Trace in detail to entries in the billing register and the accounts receivable subsidiary ledger.
- b. Verify, by examination of actual invoices and by reference to billing register entries, the numerical sequence of invoices and credit memos issued in the test period on a test basis.

## 2. General Ledger Accounts Receivable and Billing

Review activity in the billing and accounts receivable accounts in the general ledger for one month. Investigate the nature of and review support for any entries not arising from normal billing register or cash receipts journal sources, particularly non-cash credits to accounts receivable.

### 3. Cash Receipts Detail Tests

For one month during the test period:

- a. Obtain daily incoming mail cash listings or their equivalents and compare to postings in the cash receipts journal.
- b. For a period of two days obtain customer remittance advices. Review and compare in detail to duplicate deposit slips, cash receipts journal, and to postings in detail accounts receivable ledgers. Review nature of and support for miscellaneous receipts.
- c. Account for the numerical sequence of remittance advices for one week.
- d. Trace total daily receipts from the cash receipts book to entries on the bank statement and investigate any unusual lags in date of deposit.

[illegible]

4. Cash Receipts Journal Tests

Obtain the receipts journal for the test period:

- a. Trace monthly totals to general ledger postings on all of account totals.

N/A	DONE	DATE

## SUMMARY OF FINDINGS

Indicate on this schedule points indicating strengths and weaknesses in the program's system which may be appropriate for comment in the report. These include points noted from using this document as well as from all other areas of work performed during the examination.

[illegible]

Attach additional schedules in this format as required.



#### IV.

##### CLIENT TREATMENT AND CENSUS EVALUATION GUIDE

###### A. INTRODUCTION:

Evaluation of the client treatment center consists of interviewing treatment staff, ascertaining the existence of required treatment procedures and recording, and verifying reported treatment data. The major elements of the client treatment and census review are:

- Treatment process and services provided.
- Client census including frequency and duration of client treatment contacts.
- Content of client case records.

A. TREATMENT PROCESS AND SERVICES PROVIDED:

Summary of Requirements:

The following supportive services must be available:

- Recreation
- Rehabilitation (Vocational)
- Individual, Family and Group Counseling
- Medical Services under Physician Supervision
- Emergency Services (24 Hours per Day)
- Referral Services Including a Current List of Resources
- Follow-Up Services

In addition, most programs are currently providing community consultation and education services. While these services for alcoholism treatment programs are not required, evaluation is merited due to the amount of staff time spent in these activities.

Evaluation Procedures:

To assess whether all required services are available, interview the treatment coordinator and prepare descriptions of the services offered. For each service program (inpatient, outpatient, residential, etc.) describe agency procedures for intake, counselor assignment and provision of supportive services, such as individual and group counseling, vocational rehabilitation, etc.

.Are all required services available?

.During review of active client case records for the most recent month (see below) verify and document the frequency of supportive service contact for each service provided.



In addition, perform the following steps for emergency services, referral and follow-up services, and community consultation and education activities.

1. Emergency Services:

To assess the extent to which emergency services are provided, perform the following steps:

.Obtain and review the schedule of staff assigned for 24-hour, 7 day a week coverage for emergency services.

.Is a treatment professional on call for face-to-face contact at all times?

.Document the emergency services telephone number and document the method by which it is communicated to the public.

2. Termination Procedures and Follow-up and Referral Services:

To assess the extent to which a system of client termination and follow-up and a system of referring clients to other service agencies have been implemented, perform the following steps:

- a. Describe the internal program procedures for documenting client termination and conducting client follow-up and referral after discharge from the treatment facility. Obtain access to case records of discharged or inactive clients.

.To verify that stated program procedures are actually operating, select a sample of 15 inactive clients discharged in the last six months and complete the "Termination and Follow-up Documentation Worksheet", Exhibit IV-15.

.Do results indicate that the program has implemented a client follow-up system?

.Are reasons for client termination documented?

.Does it appear that the agency utilizes other service programs for client referral?

3. Community Consultation and Education Activities:

To assess the extent to which the agency plans and monitors community consultation and education activities, interview the program director and perform the following steps:

## EXHIBIT IV-15

TERMINATION AND FOLLOW-UP DOCUMENTATION WORKSHEET  
(INACTIVE CLIENTS)

PROGRAM NAME: \_\_\_\_\_  
REVIEWED BY: \_\_\_\_\_  
DATE: \_\_\_\_\_

[illegible]

NOTE: Sample clients terminated in last six months to obtain at least 15 case files.

- a. Describe those community consultation and education (C/E) activities conducted during the past six months. Include in the description, the following:
  1. The purposes or objectives of the C/E activities.
  2. The names of community groups or agencies contacted.
  3. The number and type of program staff conducting C/E activities.
- b. Obtain the most recent monthly report of staff hours spent on C/E activities. Trace the hours reported back to detailed supporting documentation prepared by staff such as daily or weekly time cards or logs. Are reported hours supported by detailed documentation?
- c. Does it appear that C/E activities are well planned and monitored? Consider the following:

-Can the agency show evidence that objectives of C/E activities have been achieved?

-Are progress reports prepared by staff conducting C/E activities? Are reports submitted to the program director?

-Does the frequency and nature of C/E activities justify the amount of staff positions and time spent

on C/E activities? Document the rationale for your assessment.

B. CLIENT CENSUS AND REPORTING:

Summary of Requirements:

Program reporting systems should produce accurate reports of:

- The number of active clients.
- Other data that may be requested by the Department of Institutions.

These reports should be supported by adequate documentation to validate report accuracy.

Evaluation Procedures:

1. Process for Report Preparation:

To assess the process for report preparation and methods of documentation, interview the individual(s) responsible for preparation of program reports (not financial) and perform the following steps:

- a. Prepare a brief flow chart of the steps used for preparation of the Monthly Data Report. This chart should begin with treatment staff documentation of clients served, services provided and staff hours spent, and end with submittal of the monthly report to the Department of Institutions.
- b. Describe methods used, if any, by program management to validate information supplied by treatment staff.

NOTE: If no verification is conducted, this is a weakness and should be documented.

- c. Collect copies of the Monthly Data Report for the last six months. During the interview with the individual responsible for report preparation, determine the following:

.What criteria are used for client admission and discharge for each of the following programs:

- Inpatient
- Outpatient
- Residential

.What criteria are used for determination of active versus inactive clients regarding frequency of contact?

- d. Assess whether the system used is reasonable. Interview 3-5 professional staff to verify that reporting procedures and definitions as described above have been communicated to staff. (See the "Professional Staff Interview Questionnaire" Exhibit II-2 in the Personnel Management and Staff Development Evaluation Guide.)

## 2. Accuracy of Reports:

To assess the accuracy of the Monthly Data Report, documentation of the number of outpatients served for the most recent month should be performed, as follows:

NOTE: The client census review should be conducted simultaneously with the client record review as described in the next section.

- a. Using the individual client case record or other qualified source, (medication dispensing logs, group therapy attendance logs, etc.), complete the "Outpatient Client Census Documentation Worksheet", Exhibit IV-16.

.To obtain the list of active outpatients, the evaluator should request either a centralized list of active clients or access to the active client files. The evaluator should include as active, those clients discharged during the current month who were active during the test month. The evaluator should find records available for at least the number of outpatients reported on the Monthly Data Report.

.Enter the client case number for each reported

CLIENT CENSUS DOCUMENTATION WORKSHEET

Reviewed BY: \_\_\_\_\_

Service Program: \_\_\_\_\_

[illegible]



EXHIBIT IV-17  
ALCOHOLISM TREATMENT PROGRAMS  
DOCUMENTED AND REPORTED CENSUS  
RECONCILIATION WORKSHEET  
(MONTHS)

PROGRAM NAME: \_\_\_\_\_  
REVIEWED BY: \_\_\_\_\_  
DATE: \_\_\_\_\_

CENSUS	OUTPATIENTS	
	Month	Month
REPORTED		
DOCUMENTED		
% VARIANCE		
Explain any observed variances greater than 10%:		

NOTE: For programs and sites with variances of more than 10%, an additional month must be sampled using the same procedures as for the most recently completed month.

active outpatient on the "Outpatient Client Census Documentation Worksheet", Exhibit IV-16, review documentation supplied by the program and enter a check mark (✓) in the column next to the client number FOR EACH CLIENT FOR WHOM AT LEAST ONE FACE-TO-FACE CONTACT IS DOCUMENTED FOR THE TEST MONTH.

- b. Compare the documented monthly outpatient census to the reported outpatient census for the same month.

.Complete the "Documented and Reported Census Reconciliation Worksheet", Exhibit IV-17.

.For any site or service program with a reported versus documented census variance of more than 10%, review results of analysis and probable causes of the problem with program management. Some possible causes of the problem might be:

--Failure of treatment staff to terminate clients on a timely basis.

--Poor procedures for documenting client contacts in case records or other sources.

.Complete an additional one month of census docu-

mentation for programs and sites with variances of greater than 10%.

c. Calculate the average client census as follows:

.For those programs and sites with less than 10% variance in reported versus documented census, calculate the average census for the past six months using Monthly Data Reports.

.For those programs and sites with more than a 10% variance, calculate the average census for the two months reviewed.

3. Average Utilization of Residential and Inpatient Beds:

To calculate the average utilization for residential and inpatient facilities perform the following steps:

a. Obtain attendance records from residential or inpatient facilities and determine:

.Number of beds available during the month

.Number of bed-days used during the month

b. Derive average utilization for the month by dividing the number of bed-days used during the month, by the number

of bed-days available during the month. (Number of bed-days available during the month = number of beds available during the month x number of days in the month.)

- c. If the average utilization is relatively low (70% or less) develop an assessment of why the facilities are underutilized.

(Consider)

.Does the client turnover rate appear to be excessive?

C. CLIENT RECORDS:

Summary of Requirements:

.Active client records must contain:

- Individualized Client Treatment Plan
- Date of Admission
- Physical Exam (as needed)
- Documentation of all Supportive Service Contacts
- Semi-monthly Progress Notes
- Social History
- Medical History

.A resident admission register must be maintained.

In addition, client records should be well organized, uniformly maintained, and stored in locked file cabinets in accordance with confidentiality requirements.

Evaluation Procedures:

The review of client records is to accomplish three primary objectives as follows:

.To document the frequency and duration of client treatment contact.

.To determine whether case records contain required client treatment documentation.

.To assess the quality of case record organization and maintenance including record storage.

To meet these objectives, the evaluator should perform the following evaluation procedures:

1. Methods of Recording:

To understand the program's record keeping system, interview the program treatment coordinator and perform the following steps:

a. Obtain 2-3 sample active client records and review each record with the treatment coordinator. Describe the forms used for the following:

.Date of Admission

.Social History

.Medical History

.Physical Examinations (as needed)

.Individualized Treatment Plan



PROGRAM NAME: \_\_\_\_\_

CLIENT RECORD DOCUMENTATION WORKSHEET

REVIEWED BY: \_\_\_\_\_

ALCOHOLISM TREATMENT

DATE: \_\_\_\_\_

(MONTH)

NOTE: Complete separate worksheets for inpatient, outpatient and residential programs.

Client Number	Admission Date	CONTENT OF RECORDS				FREQUENCY OF SUPPORTIVE SERVICE CONTACT BY SERVICE TYPE							Total Service Contracts
		Social History (x)	Medical History (x)	Treatment Plan (x)	Progress Notes/Plan Assessment (x)	Individual Counseling	Group Counseling	Family Counseling	Recreation	Vocational	Non-Intake Medical	Other (Explain)	
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
11.													
12.													
13.													
14.													
15.													
16.													
17.													
18.													
19.													
20.													
21.													
22.													
23.													
24.													
25.													

Records lacking Required documentation	No.	No.	No.	No.
	%	%	%	%

.Client Number:

The evaluator is cautioned to ensure client confidentiality by utilizing only the client identification number. Names may be used on-site but should be erased from worksheets before leaving.

.Admission Date:

To calculate average client retention (see below) enter the admission date for each client.

.Content of Records:

Based on the description of program procedures, look for the presence in each file of the indicated documentation.

.Frequency of Supportive Services Contact:

Record the number of documented face-to-face contacts by type of service for the most recent month. Documentation should consist of written counseling notes or other qualified sources such as group counseling attendance records.



The evaluator should request the assistance of program staff to locate all reasonably accessible documentation of contact. Family counseling contacts need not include the primary client as a participant.

NOTE: To help ensure that clients are receiving necessary services and that staff time is efficiently utilized, all supportive service contacts should be documented in case records as they occur, e.g., case files for residential clients should include documentation of individual service contacts, not just documentation of service days received. If individual contacts are not documented, this is a weakness and should be noted.

- c. To assess the extent to which progress notes in client records are consistent with individualized treatment plans and the extent to which the updating of these treatment plans reflects progress which has been reported, perform the following steps:

.Select a sample of (15) client case records from the "Client Record Documentation Worksheet", Exhibit IV-18, and perform the following steps:

.Review the individualized treatment plan and progress notes for each case record. Determine whether they are consistent with one another, i.e., whether progress toward the specific objectives in the treatment plan is mentioned in the notes, and whether treatment staff recommendations become part of the plan objectives which are mentioned in subsequent progress notes.

.Are progress notes consistent with treatment plans?

.Have there been at least semi-monthly progress notes?

d. Summarize results of the record documentation review by calculating the following statistics:

.Client Retention:

Based on the date of admission, determine the number and percent of clients who have been active for:

0-1 Month (less than 30 days)

1-3 Months (30-90 days)

3-6 Months

6-+ Months

.Record Content:

Calculate the number and percent of client  
records lacking the required documentation.

.Frequency of Supportive Services Contact by Client:

Calculate the number and percent of clients  
provided services the following number of times  
during the most recent month:

0

1-3

4-6

7-9

10-+

.Frequency of Supportive Services contact by admission  
date of client:

Calculate the number and percent of clients in  
each of the retention categories provided  
services in each of the contact of frequency

CATEGORIES. Complete the "Frequency of Supportive Services Contact By Admission Date of Client", Worksheet Exhibit IV-19.

.Frequency of Supportive Service contact by service:

Calculate the total number and percent of contacts provided to all clients by service during the most recent month, as follows:

<u>TYPE OF SERVICE</u>	<u>NO. OF CONTACTS</u>	<u>% OF TOTAL CONTACTS</u>
Individual Counseling		
Group Counseling		
Family Counseling, etc.		
TOTAL		100%

e. Analyze results of the record documentation review.

Consider the following:

.How does the program compare with other programs in client retention?

.Is required content present for at least 90% of all records reviewed? If not, discuss reasons with program management.

# EXHIBIT IV – 19

Frequency of Supportive Services Contact By

Admission Date of Client Worksheet

LENGTH OF TIME CLIENT HAS BEEN ACTIVE	FREQUENCY OF SUPPORTIVE SERVICE CONTACT FOR THE MONTH					
	0	1-3	4-6	7-9	10+	TOTALS
0 – 1 Month						100% of clients active 0-1 month
1 – 3 Months						100% of clients active 1-3 months
3 – 6 Months						100% of clients active 3-6 months
6 – + Months						100% of clients active 6-+ months
TOTALS	100% of clients with no contacts	100% of clients with 1 - 3 contacts	100% of clients with 4 - 6 contacts	100% of clients with 7 - 9 contacts	100% of clients with 10 - + contacts	100% of all clients

.Do records accurately reflect the extent and nature of supportive services provided? How does the program compare with other programs in frequency of contact?

.Does it appear that newer clients have a greater frequency of service contact?

.Are overall service contacts by type reasonably distributed, or does it appear that only one or two types of services are being provided and documented?

.Are records stored in locked file cabinets? Do records appear well organized and uniformly maintained?

.Review all findings with program management and identify reasons for problems observed and solutions program management intends to implement.

NOTE: These solutions should become part of the program's treatment objectives for the next program year.

REQUIREMENTS SPECIFIC TO EMERGENCY CARE/  
DETOXIFICATION

Specify the type of setting:

- ☐ non-hospital setting
- ☐ non-hospital setting, but affiliated with a general hospital
- ☐ part of the medical service of a general hospital



Does the program provide the following:

- ☐ sobering up in a safe, protected environment
- ☐ protection from the development of sometimes life-threatening mental and physical symptoms
- ☐ screening for the presence of medical-surgical conditions often associated with alcoholism or as a consequence of drunkenness and expeditious referral if warranted
- ☐ encouragement, advice, counseling and referral in helping the individual control his drinking problem



Documentation that services are provided on a 24-hour, 7 day a week basis.



A record of the resident's clothing and valuables, signed by the resident or sponsor and a staff member.



A minimum of one staff member on duty for admitting, treating and discharge purposes.

REQUIREMENTS SPECIFIC TO THE INTERMEDIATE CARE  
COMPONENT

- ☐ Documentation of recreation and rehabilitation activities geared for therapeutic purposes and under the guidance of program staff.
- ☐ Documentation that supervision and services are available 24-hours a day, 7 days a week.
- ☐ Documentation of a sliding fee scale for clients, based on ability to pay.
- ☐ Documentation that staff includes the following:
  - \_\_\_\_\_ a house manager
  - \_\_\_\_\_ a minimum of one staff member for admitting, treating and discharging residents

REQUIREMENTS SPECIFIC TO OUTPATIENT CARE

- ☐ Active outreach philosophy.



## CRITERIA FOR RESIDENTIAL PROGRAMS

- ☐ 30-day Meal Menu including snacks.
- ☐ Documentation that medical service is available under the supervision of a physician.
- ☐ Documentation of written policies and procedures developed with the assistance and written approval of a physician or representative of the medical board. The policies and procedures should address the following:
  - care of occupants having minor/acute illnesses
  - medical emergencies including dangerous behavior
- ☐ A written agreement with the hospital for medical/surgical care when needed.
- ☐ Medical evaluation is incorporated into the admission procedure which insures a personal observation and inquiry is made of each client as to the following:
  - history of chronic illness
  - physical disability
  - vermin infestation
  - possible contagious
  - notation regarding appearance
- ☐ First aid equipment and corresponding written procedures.
- ☐ Agreement with Mental Health for emergency consultation.
- ☐ Procedures which insure that medication is handled in accordance with provisions of applicable State and Federal laws and regulations.
  - ☐ Administered by qualified staff
    - RN's
    - LPN's
  - ☐ Self administration
- ☐ Procedures for methods of cleaning, handling and storing all medications, medical supplies and equipment.



APPENDIX A

PROGRAM EVALUATION CHECKLIST



MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
ORGANIZATION AND PROGRAM MANAGEMENT					
A. <u>Structure</u> Are current lines of authority and reporting relationships documented?					
Are current lines of authority and reporting relationships communicated to staff?					
B. <u>Goals, objectives, and program self-evaluation</u> Is there a written, current statement of goals and specific and measurable objectives?					
Are program objectives communicated to clients and the community?					



MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
Evaluation topic					
Is progress in the accomplishment of objectives monitored?					
Are there monthly written reports of progress in accomplishing objectives?					
Is there annual self-evaluation to determine compliance with contract requirements?					
C <u>Policies, procedures, plans</u> Does the agency have all required written policies, procedures, and plans?					
Is a policy manual amenable to formal and regular revision and maintenance available and distributed to staff?					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date of \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable			
	no action	action recommended	action recommended	action required		
D. <u>Governing Boards/Advisory Boards</u> Does the nongovernment agency have a governing board representative of the community?						
Does the board meet as often as required and keep meeting minutes? Are at least two-thirds of board membership in attendance at each meeting?						
Does the board play an active role in monitoring and directing the agency?						
Does the government agency have an advisory board representative of the community?						
Does the board meet as often as required and keep meeting minutes? Are at least two-thirds of Board membership in attendance at each meeting?						



MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

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Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Review approved by \_\_\_\_\_

Date (s) \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	acceptable action recommended	unacceptable action required		
Does the board play an active role in guiding and advising the agency?					
E. <u>Facilities</u>					
Is the program facility licensed?					
Are program facilities adequately large, well maintained, and safe?					
Are client records stored in locked file cabinets?					
(Alcoholism treatment only ) Does the agency have \$300,000 of liability insurance on total operations, including transportation?					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s): \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	acceptable action recommended	unacceptable action required		
PERSONNEL MANAGEMENT AND STAFF DEVELOPMENT					
A. Job descriptions and staff classification Does the agency systematically develop qualifications for and job descriptions of each staff position?					
Are professional personnel certified by the Department of Institutions? For those not certified, has an application for certification been sent?					
Has the agency developed a position classification system which differentiates between levels of responsibility and complexity of work?					
B Personnel files and staff performance evaluation Is a personnel file maintained for each					

MONTANA DEPARTMENT OF INSTITUTIONS  
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PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
employee? Do personnel files contain the suggested items?					
Is annual performance evaluation of all staff conducted and recorded in personnel files?					
C <u>Staff development</u> Is there one individual responsible for training implementation?					
Is regular staff training consistent with the annual training plan provided?					
Have all professional staff participated in orientation training and recent ongoing training?					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s): \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
(Mental health only) Have professional staff had an opportunity to attend the required number of internal and external workshops during the past twelve months?					
D. <u>Use of volunteers</u> Are written volunteer selection and evaluation criteria distributed to volunteers?					
Are volunteers adequately trained and supervised by full-time professional staff?					
Are hours contributed by volunteers recorded?					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

• PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s): \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
E. Turnover rate, vacancies and staff availability Are client waiting lists excessive?					
Do staff believe they are generally available to meet client requests for services?					
Is the turnover rate acceptable?					
Does program management aggressively pursue filling vacant professional positions?					
Are staffing levels reasonable?					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s): \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	no action	acceptable action recommended	unacceptable action required			
F. <u>Subcontracts and service agreements</u> Does the agency have written agreements with all other service agencies providing client services for which the agency pays?						
Do written agreements with sub-contractors include the required minimum specifications?						

**MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION**

**PROGRAM EVALUATION CHECKLIST**

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
<b>FINANCIAL MANAGEMENT</b> A Current, historical and future financial condition. Is actual financial information, including income and expenses, readily available from agency accounting records and reports?					
Has the agency had sufficient income to meet its expenses?					
Can present or potential funding sources be expected to provide continued financial support to the agency?					
Does a written third party payment plan exist? Is the plan in operation?					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s): \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	acceptable no action	action recommended	unacceptable action required		
B. Budgeting performance and cash management Is there an agency budget for the current fiscal year?					
Is the agency budget consistent with the budget submitted to the Department of Institutions?					
Are monthly reports of actual versus budgeted revenue and expenditures prepared and available?					
Are significant variances occurring?					



MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s): \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable			
	no action	action recommended	action required			
If so, are steps being taken to remedy variances? Are revisions to the budget approved by the Department of Institutions?						
Is there cash planning (budgeting) on a month-to-month basis to ensure sufficient cash is available?						
Has the program developed a dollar surplus for working capital?						
(Mental health only) Are available non-state funds spent prior to state funds?						
(Mental health only) Are available cash reserves less than or equal to 17% of the Center's total annual budget?						

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable			
	no action	action recommended	no action	action required		
<p>CLIENT TREATMENT AND CENSUS (MENTAL HEALTH PROGRAMS)</p> <p>A. Treatment process and services provided</p> <p>Does the program provide all the following services as specified?</p> <ul style="list-style-type: none"> <li>Emergency services 24 hours per day 7 days per week with a treatment professional available for face-to-face contact and telephone service</li> <li>Outpatient services at appropriate times</li> <li>Partial hospitalization service at least 4 hours per day, 5 days per week</li> <li>Inpatient services.</li> <li>Consultation and Education and Program Development services according to a formal plan.</li> </ul>						

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable			
	no action	action recommended	action required			
<ul style="list-style-type: none"> <li>Transitional services according to a formal plan.</li> <li>Specialized services for Indians, children, the elderly, drug abusers, and alcoholics, with at least one treatment professional per region for each target population.</li> <li>Screening and evaluation in accordance with the WSSH contract</li> <li>Documentation of termination, and followup services to make contact with discharged clients at regular intervals during the 12 months following discharge.</li> <li>Utilization/Peer Review service to determine whether service is clinically sound and appropriate</li> </ul>						

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
<p>— A wide range of supportive services including individual, family, and group counseling, occupational and recreational therapy; and chemotherapy, made available to center patients regardless of the program to which they are assigned.</p> <p>— Referral services.</p>					
Does it appear that C/E activities are well planned and monitored?					
Does the frequency and nature of C/E activities justify the amount of staff time spent on C/E activities?					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable action required		
	no action	action recommended			
B. <u>Client census and reporting</u>  Does the program reporting system produce accurate reports of — The number of active clients.  — Other data that is requested by the Department of Institutions.					
Are program reports supported by adequate documentation to validate report accuracy?					
Do program supervisors validate information supplied by treatment staff?					
Is the program's average utilization of residential and inpatient beds below 70%?					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable			
	no action	action recommended	action required			
<p><u>C. Client records</u></p> <p>Do active client records contain the following required items?</p> <ul style="list-style-type: none"> <li>– Individualized client treatment plans and progress notes.</li> <li>– Drug use profile. (Illicit drugs )</li> <li>– Documentation of all face — to — face service contacts.</li> <li>– Past and present health status.</li> <li>– A record of client admission date.</li> </ul>						
<p>How does the program compare with other programs in frequency of supportive services contact by client and service, client retention, and frequency of contact by retention category?</p>						

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program name \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Director \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable			
	no action	action recommended	action recommended	action required		
Are progress notes consistent with treatment plans?						
Are client records well organized, uniformly maintained, and stored in locked file cabinets?						
D <u>Patient eligibility</u>  Do patients released from WSSH for whom CMHC's are claiming reimbursement for services provided under Article III - WSSH contract, meet the patient eligibility criteria?						

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable action required		
	no action	action recommended			
<p><u>CLIENT TREATMENT AND CLIENT CENSUS (DRUG ABUSE TREATMENT PROGRAMS)</u></p> <p>A. <u>Treatment process and services provided</u></p> <p>Does the program provide the following services as specified?</p> <ul style="list-style-type: none"> <li>— Educational services, vocational counseling, job development and placement services</li> <li>— Legal services</li> <li>— Referral services</li> <li>— Documentation of termination and followup services to determine the results of referral.</li> <li>— Individual, family, and group counseling.</li> <li>— Medical services.</li> </ul>					



MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date /s/ \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable		
	no action	action recommended	action required		
2. <u>Client census and reporting</u> Does the local CODAP reporting system produce accurate reports of - The number of active clients at the end of the month, i.e., those receiving face-to-face contacts within the last 30 days? - Other data requested by the Department or Institutions?					
Are reports supported by adequate documentation to validate report accuracy?					
Is the program's average utilization of residential and inpatient beds below 70%?					

MONTANA DEPARTMENT OF INSTITUTIONS  
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PROGRAM EVALUATION CHECKLIST

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s): \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
<p>C. <u>Client records</u></p> <p>Do all client records include the following required documentation?</p> <ul style="list-style-type: none"> <li>— Individualized treatment plan.</li> <li>— Results for 90-day plan assessment for outpatients and 30-day plan assessment for residents.</li> <li>— Monthly progress reports and documentation of all supportive service contacts.</li> <li>— Physical and laboratory examinations.</li> <li>— Personal history.</li> <li>— Medical history</li> <li>— Drug history.</li> <li>— Results of urine testing.</li> </ul>					

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date: \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable			
	no action	action recommended	action required			
-How does the program compare with other programs in frequency of supportive services contact by client and service, client retention and frequency of service contact by retention category?						
Are client records well organized, uniformly maintained, and stored in locked file cabinets?						
D <u>Urine surveillance</u> For residential programs, are urine samples taken weekly? Are urine specimens analyzed monthly for opiates, methadone, amphetamines and barbituates?						
Do the laboratories which perform urinalysis for the program comply with all applicable Federal proficiency testing standards?						

MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION

PROGRAM EVALUATION CHECKLIST

Program title: \_\_\_\_\_

Type of review: \_\_\_\_\_

Review completed by: \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluation topic	Findings				Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable			
	no action	action recommended	action required			
How do urinalysis statistics compare with other programs?						

MONTANA DEPARTMENT OF INSTITUTIONS  
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PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by: \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	acceptable		unacceptable		
	no action	action recommended	action required		
<p>CLIENT TREATMENT AND CENSUS (ALCOHOLISM TREATMENT PROGRAMS)</p> <p>A. Treatment process and services provided _____</p> <p>Does the program provide the following services, as specified?</p> <ul style="list-style-type: none"> <li>— Recreation services</li> <li>— Rehabilitation (vocational) services</li> <li>— Medical services under physical supervision.</li> <li>— Emergency services 24 hours per day, 7 days per week, with treatment professional available for face-to-face contact and telephone service.</li> <li>— Documentation of termination and followup and referral services, including a current resource list.</li> <li>— Consultation and Education services</li> </ul>					

MONTANA DEPARTMENT OF INSTITUTIONS  
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PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date (s) \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	acceptable no action	action recommended	unacceptable action required		
<p>B. <u>Client census and reporting</u></p> <p>Do the program reporting systems produce reports of</p> <ul style="list-style-type: none"> <li>– The number of active clients</li> <li>– Other data requested by the Department of Institutions</li> </ul> <p>Are reports supported by adequate documentation to validate report accuracy?</p> <p>Is the program's average utilization of residential and inpatient beds below 70%?</p>					
<p>C. <u>Client records</u></p> <p>Do active client records contain the following required items?</p>					

MONTANA DEPARTMENT OF INSTITUTIONS  
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PROGRAM EVALUATION CHECKLIST

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by: \_\_\_\_\_

Review approved by \_\_\_\_\_

Date(s) \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	no action	action recommended	unacceptable action required		
<ul style="list-style-type: none"> <li>Individualized treatment plan</li> <li>Date of admission</li> <li>Physical exam, as needed</li> <li>Documentation of all supportive service contacts</li> <li>Semi-monthly progress notes re treatment plan</li> <li>Social history</li> <li>Medical history</li> </ul>					
Is a resident admission register maintained (for residential programs)?					

**MONTANA DEPARTMENT OF INSTITUTIONS  
ADAPTIVE SERVICES DIVISION**

**PROGRAM EVALUATION CHECKLIST**

Program title \_\_\_\_\_

Type of review \_\_\_\_\_

Review completed by \_\_\_\_\_

Date(s) \_\_\_\_\_

Review approved by \_\_\_\_\_

Date \_\_\_\_\_

Evaluation topic	Findings			Recommendations for corrective action	Reference to supporting documents
	acceptable no action	action recommended	unacceptable action required		
How does the program compare with other programs in frequency of supportive services contact by client and service, client retention and frequency of contact by retention category?					
Are client records well organized, uniformly maintained, and stored in locked file cabinets?					



## SECTION 6

CERTIFICATION PHILOSOPHY

WHAT IS CERTIFICATION?

CERTIFICATION BOARD

CERTIFICATION BOARD MEMBERSHIP

FUNCTIONS OF CERTIFICATION BOARD

CERTIFICATION STANDARDS KEY

CERTIFICATION STANDARDS



## CERTIFICATION PHILOSOPHY STATEMENT

Any statement of philosophy attempts to answer "why", as does this statement have the intent of answering "why". Why certify workers in the State of Montana and why certify, or attach credentials to alcoholism and drug counselors? The rationale put forth herein is an attempt to answer the "why" as stated previously.

As a legal, public entity the Montana Alcohol and Drug Abuse Division has the following mandate: To oversee all treatment agencies delivering services to the drug and/or alcohol users (abusers) in the State. In order to insure adequate service delivery to those citizens who may be chemically addicted or habitual users of substances (alcohol and/or drugs) it becomes necessary to place quality controls upon programs and their personnel. One way of regulating and providing for high quality staff is to initiate and maintain a counselor certification system. In this system requirements are established regarding counselor education, training, and experience. Persons who meet the minimum requirements become eligible to be certified and those who do not are either excluded from the system or re-routed through the system.

By placing requirements upon counselors in three areas - education, training, and experience it is hoped that more effective services are rendered by these individuals to the persons they treat. The assumption being that all workers can be more effective by receiving training and education which is job related as well as having experience specific to their field.

This, then is the underlying assumption about certification which the State makes as it responds to its mandate and missions.

## WHAT IS CERTIFICATION?

Certification is the procedure wherein a designated legal body says to the individual that they are qualified to do a specific job. It is a process whereby the individual must meet requirements in three specific areas: training, education and experience. In order to be certified in the State of Montana an individual must first choose whether he wishes to be certified as a drug counselor, an alcoholism counselor, or both. Once this decision is made application to the certification board is made.

Certification is an evaluation of an individual's education, training and experience compared with the standards which are set minimum requirements. A person is then certifiable at a specific level. If a person does not fully meet the requirements he may be certified on a provisional basis. Provisional certification is for a specific period of time, and in that time frame the candidate carrying a provisional certificate must meet all specified requirements and conditions. At the end of the time period if a candidate has fulfilled all requirements he/she receives full certification. If, however, the candidate has not fulfilled said requirements the provisional certificate is revoked. All individuals working in the State of Montana as a paid counselor in a drug or alcoholism treatment program, or in a program offering said services, must be certified.

During FY1978 the certification procedure will be implemented only for Treatment and Rehabilitation Counselor Class II.

## HOW THE CERTIFICATION BOARD IS CREATED

The Substance Abuse Certification Board shall consist of appointees of the Director of the Department of Institutions. Appointees shall serve a minimum of one (1) year and a maximum of three (3) years.

This Board is created for the purpose of reviewing, maintaining, and making specific recommendations to and for the counselor certification program as maintained by the State Alcohol and Drug Abuse Division, Department of Institutions. Said Board shall review and make decisions regarding the appropriateness of each applicant to be certified, either provisionally or fully. All applicant requests and subsequent material comes before the Board for a decision on the appropriateness and eligibility of the candidate.

This Board shall operate in concert with the Alcohol and Drug Abuse Division and/or its designees who shall supply the Board with all necessary applicant information or technical assistance.

The above shall be provided at Board request and/or as necessary in the application procedure. This Board shall be seen as the final authority in all cases regarding counselor certification; however, all applicants shall have the right to request a variance or appeal a Board decision. (See attached for specifics regarding The Appeal Procedures.)

## CERTIFICATION BOARD MEMBERSHIP

This Board shall consist of six (6) members selected by the following criteria:

1. Person, or persons on the Board, should have had prior experience with Montana's certification standards. (This could be done by recruiting 1 or 2 of the people from the original certification committee).
2. Person or persons on the Board should have had experience either with the chemically dependent or working in a program serving the chemically dependent (drug and/or alcohol abusers).
3. A person or persons on this Board must be willing and able to attend to monthly meetings. Additionally they should be willing and able to secure leave time for any and all necessary Board training. (Board training will be a necessary prerequisite, in order to insure that all Board members are fully versed in the certification procedures and requirements. Training shall be provided by the Alcohol and Drug Abuse Division.)
4. A person or persons should have had prior experience with boards and/or committees. Prior service on an advisory board or committee which exists or existed to serve a public interest. (All expenses, ie. travel and per diem costs shall be paid by the Alcohol and Drug Abuse Division, Department of Institutions, State of Montana. They shall be paid at the current existing State rates for meals, lodging, and mileage).

## FUNCTIONS OF THE CERTIFICATION BOARD

There will be three (3) primary functions of the Certification Board:

1. The Certification Board will receive and/or review all applications and applicants. Persons seeking certification shall submit the required paperwork to the Addictive Diseases Division Training Unit for review. This review is done to insure that applicants meet the minimum requirements, and that all the necessary information accompanies the application. After the review by the Alcohol and Drug Abuse Division the application and applicant are presented to the Board for their review. The Board can make one of four primary decisions:
  - a. Move to fully certify the individual at a specific level, with no riders or stipulations.
  - b. Move to provisionally certify an individual at a specific level with stipulations and further requirements. All requirements put on provisional certificate must be completely explained, and be a result of certification deficit. The provisional certificate must carry a time frame within which all requirements are to be fulfilled.
  - c. Move not to certify the individual at any level. In all cases where this decision is rendered the Board must provide the applicant with its rationale for the decision in writing. Additionally, if an individual receives such a decision, they will have the right of appeal.
  - d. Good cause appearing, the Certification Board may require a personal oral interview of any applicant. In the event

of this occurrence the Board shall be in agreement regarding the purpose for the interview and shall agree upon the questions to be asked of the applicant. If an applicant is required to meet with the Board he shall travel to said Board's meeting place at his own expense.

2. The Certification Board will establish a fee for certification. This money shall be collected and administered by the Department of Institutions, Alcohol and Drug Abuse Division. (Currently fees of \$20 for initial applicants and \$10 for renewal applications are under consideration). The money should be considered for use in partially deferring the Boards expenses and/or for use in reducing the overall costs of administering this certification system.
3. The Certification Board will operate from a standard set of policies, procedures and guidelines. Additionally, the Board shall establish and maintain a counselor code of ethics. The violation of said code shall be due cause for a person to be brought to the attention of the Board for possible disciplinary action. Such disciplinary action can be in the form of revocation and/or suspension of a counselor's certificate.
  - a. Suspension is the temporary removal of a certificate for an infraction of the code. The length of suspension must be specific regarding the beginning and ending dates, and all stipulations must be in writing.
  - b. Revocation is the permanent withdrawal of a counselor certificate. This can be done only following a period of suspension. Once the Board has moved to revoke a person's



certificate the decision is seen as permanent and final. (Decisions will be pending the outcome of any and all appeals to the Board which may effect a case). In all cases involving a suspension and/or revocation the Board can act only in relation to its mandate. Additionally, all cases must be a clear violation of the code and be brought to the attention of the Board by an individual or a program. Allegations shall be supported by evidence and all complainants shall appear before the defendant and the Board in the course of due Board process. All defendants have the right of appeal and shall be considered innocent until otherwise shown.

In general, the function of the Certification Board is to help maintain and operate the counselor certification system in the State of Montana. They (the Board) are to work in cooperation and conjunction with the Alcohol and Drug Abuse Division. The Division shall supply the Board with the necessary aid to the Board's regulatory and maintenance functions. Board decisions are considered final and binding, with all persons being given the right of appeal.

## CERTIFICATION STANDARDS KEY

The Counselor Certification Standards contain four (4) classes or levels, 1 through 4, with each class having separate and minimum requirements. During 1977 we will only be certifying the Class II level. The following explains the use of the standards:

On the left hand side note the column or section labeled "skill and subject areas". These are the specific required courses and skills that a counselor must have, written in terms of subjects. The next columns marked, "learning requirements and methods", tell how the learning can be achieved. If, for instance, the words training or education occur, the learning will be in a formal environment such as a college, or in a training program which is specific to the subject. If the learning requirement is experience or on the job training, no formal education requirement is made. Whenever the standards only call for experience or on-the-job training, no other requirement exists. Experience in this specific definition is: Work in a drug or alcohol treatment program, as a full time paid counselor. Volunteer work does not count. The next columns are labelled "minimum requirements". The minimum requirements tell how much of what subject an individual must have. For instance as a Class II Counselor, a person will have one year's experience or a course in General Psychology. Either one would meet the Class II requirement for that subject. The three things being monitored by certification are training, education and experience, any of which may be seen as valid learning experiences. Some requirements are met by either experience or training, other requirements are fulfilled by having both training and experience. (See standards for

the specific requirements). The numbers in the minimum requirement columns translate in the following way: Training hours are clock hours, i.e. 15-20 hours of training is the time spent in a formal training session. For the training hours, multiply the number of hours spent in training by the number of days the session lasted, this gives you the training hours. "Number of courses" is the educational requirement measured in terms of a three (3) credit hour, college level course. In other words, one (1) course means it had to have been taken in a college or university and three (3) hours of credit will have been received. One (1) in the experience column means one (1) year experience.

To repeat then, read the columns from the left to the right. All information from the specific title through the minimum learning requirements are available in the package labeled "Certification Standards".

# C E R T I F I C A T I O N   S T A N D A R D S

## ALL PROGRAM AREAS CLASS 1

SKILL & SUBJECT AREA	LEARNING REQUIREMENTS	LEARNING METHODS	MINIMUM REQUIREMENTS		
			Trng. Hrs.	No. of Courses	Exp.
PHARMACOLOGY					
Chemical Nature of Drugs Medical Use of Drugs Phys. & Psych. Effects of Alc. and Drugs	Training Training Training	Formal Education or Training Formal Education or Training Formal Education or Training			
MEDICINE					
Basic First Aid Emergency Medical Treatment	Awareness Awareness	Exp. or On-the-job Training Exp. or On-the-job Training			
LAW					
Federal, State & Local Alc. & Drug Laws Drug Law Enforcement Basic Legal Process	Awareness Awareness Awareness	Exp. or On-the-job Training Exp. or On-the-job Training Exp. or On-the-job Training			
OTHER					
Confidentiality Inter-Disciplinary Standard Operating Policy Organization	Training Awareness Awareness	Formal Training Exp. or On-the-job Training Exp. or On-the-job Training			

# C E R T I F I C A T I O N   S T A N D A R D S

## TREATMENT AND REHABILITATION CLASS 2

SKILL & SUBJECT AREA	LEARNING REQUIREMENTS	LEARNING METHODS	MINIMUM REQUIREMENTS		
			Trng. Hrs.	No. of Courses	Exp.
SUBSTANCE ABUSE INFORMATION					
Chemical Nature of Alc. & Drugs Medical Use of Drugs Phys. & Psych. Effects of Alc. & Drugs	Training + Experience Training + Experience Training + Experience	Any (In-service Trng. or College) Any Any	15-20	1	1
PSYCHOLOGY					
Mental Health (General Psy.) Intra-Personal Relations Personality Development Diagnosis Overview of Treatment Process/ Treatment Plan Development Treatment Methods/Inter. Discip. Orientation	Training or Experience Exp. or On-the-job Training Exp. or On-the-job Training Exp. or On-the-job Training Training Exp. (On-the-job training)	Any Exp. or On-the-job Training Exp. or On-the-job Training Exp. or On-the-job Training Training On-the-job Training	15	1	1 1 1 1 1 1
GUIDANCE AND COUNSELING					
Interviewing Individual Counseling Group Counseling	Exp. or On-the-job Training Exp. or On-the-job Training Exp. or On-the-job Training	Exp. or On-the-job Training Exp. or On-the-job Training Exp. or On-the-job Training			1 1 1

# C E R T I F I C A T I O N   S T A N D A R D S

## TREATMENT AND REHABILITATION CLASS 2 (Continued)

SKILL & SUBJECT AREA	LEARNING REQUIREMENTS	LEARNING METHODS	MINIMUM REQUIREMENTS		
			Trng. Hrs.	No. of Courses	Exp.
MEDICINE Basic First Aid Emergency Medical Treatment	Training Training	Formal Education or Training Formal Education or Training	15-20 20-25	1 1	
	Experience or Awareness Exp. or Training	Exp. or On-the-job Training College or Exp. or In-svc. Trng.	15	1	1
SOCIOLOGY Interpersonal Relations Minorities and Social Conditions	Awareness of Community Awareness of Community	Exp. or On-the-job Training Exp. or On-the-job Training			1 1
ENVIRONMENT Catchmt Area Demographics Catchmt Area Social Structure	Experience Experience Experience	Exp. or On-the-job Training Exp. or On-the-job Training			1 1 1
COMMUNITY RESOURCES Types & Uses of Resources Availability of Resources Linking Client to Resources	Awareness Awareness	In-service Training In-service Training	15-20 15-20		
EVALUATION Concepts of Evaluation Measurement of Methods	Manual	Self-taught		Successful Completion of Manual	
OTHER Confidentiality					

# C E R T I F I C A T I O N   S T A N D A R D S

## TREATMENT & REHABILITATION CLASS 3

SKILL & SUBJECT AREA	LEARNING REQUIREMENTS	LEARNING METHODS	MINIMUM REQUIREMENTS		
			Trng. Hrs.	No. of Courses	Exp.
SUBSTANCE ABUSE INFORMATION  (chemical Nature of Alc. & Drugs Medical Use of Drugs Phys. & Psych. Effects of Alc. & Drugs Causative Factors of Alcoholism	Training + Exp. Training + Exp.	Formal Education or Trng. + Exp. Formal Education or Trng. + Exp.	15-20 15-20	1 1	2 2
	Training + Exp. On-the-job Training	Formal Education or Trng. + Exp. Formal Ed. or In-svc. Trng.	15	1	2
PSYCHOLOGY  Mental Health (General Psy.) Intra-Personal Relations Personality Theory Diagnosis Overview of Treatment Process/ Treatment Plan Development Treatment Methods/Inter. Discip. Orientation	Training or Exp. Training + Experience Training + Experience Training + Experience	Formal Education or Training Training Training Training	15 15 15	1 1 1	1 1 1
	Training + Experience	Formal Education or Training	15-30	1	1
	Training + Experience	Formal Education or Training	15-30	1	1
GUIDANCE AND COUNSELING  Interviewing Individual Counseling Group Counseling	Training + Experience Training + Experience Training + Experience	Exp. + Trng. or Education Exp. + Trng. or Education Exp. + Trng. or Education	15 15 15	1 1 1	1 1 1

# C E R T I F I C A T I O N   S T A N D A R D S

## TREATMENT & REHABILITATION CLASS 3 (Continued)

SKILL & SUBJECT AREA	LEARNING REQUIREMENTS	LEARNING METHODS	MINIMUM REQUIREMENTS		
			Trng. Hrs.	No. of Courses	Exp.
MEDICINE Basic First Aid Emergency Medical Treatment Med. Aspects of Alc. (Phys. Effects)	Training Training Training	Formal Education or Training Formal Education or Training Formal Education or Training	15-20	1	
			20-25	1	
			15	1	
SOCIOLOGY Interpersonal Relations Minorities and Social Conditions	Training In-Svc. Exp. or Training	Formal Education or Training College or Exp. or In-svc. Trng.	15	1	1
			15	1	1
ENVIRONMENT Catchmt Area Demographics Catchmt Area Social Structure	Awareness of Community Awareness of Community	Exp. or On-the-job Training Exp. or On-the-job Training			1
					1
COMMUNITY RESOURCES Types & Uses of Resources Availability of Resources Linking Client to Resources	Training + Experience Training + Experience Training + Experience	Formal Ed. or Training Formal Ed. or Training Formal Ed. or Training	15	1	1
			15	1	1
			15	1	1
EVALUATION Concepts of Evaluation Measurement Methods	Training Training	Formal Ed. or Training Formal Ed. or Training	15	1	
			15	1	
OTHER Confidentiality	Manual	Self-taught	Completion of Manual		



# CERTIFICATION STANDARDS

## TREATMENT & REHABILITATION CLASS 4

SKILL & SUBJECT AREA	LEARNING REQUIREMENTS	LEARNING METHODS	MINIMUM REQUIREMENTS		
			Trng. Hrs.	No. of Courses	Exp.
SUBSTANCE ABUSE INFORMATION	Training + Exp.	Formal Ed. or Trng. + Exp.	15	1	3
	Training	Formal Ed. or Trng. + Exp.			3
	Training	Formal Ed. or Trng. + Exp.			3
	On-the-job Training	Formal Ed. or Trng.	15	1	
PSYCHOLOGY	Training + Exp.	Formal Ed. or Trng.			
	Training + Exp.	Any	30-45	2	3
	Training	Formal Ed. or Trng.	30-45	2	3
	Training + Exp.	Formal Ed. or Trng. + Exp.	30-45	2	3
	Training + Exp.	Formal Ed. or Trng. + Exp.	30-45	2	3
	Training + Exp.	Formal Ed. or Trng. + Exp.	30-45	2	3
	Training + Exp.	Formal Ed. or Trng. + Exp.	30-45	2	3
GUIDANCE AND COUNSELING	Training + Exp.	Formal Ed. or Trng.	15	1	3
	Training + Exp.	Formal Ed. or Trng. + Exp.	45+	3	3
	Training + Exp.	Formal Ed. or Trng. + Exp.	45+	3	3
	Training + Exp.	Formal Ed. or Trng. + Exp.	45+	3	3

# C E R T I F I C A T I O N   S T A N D A R D S

## TREATMENT & REHABILITATION CLASS 4 (Continued)

SKILL & SUBJECT AREA	LEARNING REQUIREMENTS	LEARNING METHODS	MINIMUM REQUIREMENTS		
			Trng. Hrs.	No. of Courses	Exp.
MEDICINE					
Basic First Aid	Training	Formal Ed. or Training	15-20	1	
Emergency Medical Treatment	Training	Formal Ed. or Training	20-25	1	
Medical Aspects of Alcoholism (Phys. Effects)	Training	Formal Ed. or Training	15	1	
SOCIOLOGY					
Interpersonal Relations	Training + Experience	Formal Ed. or Training	30+	2	3
Minorities and Social Cond.	Training + Experience	Formal Ed. or Training	15	1	2
ENVIRONMENT					
Catchmt Area Demographics	Awareness of Community	Exp. or On-the-job Training			2
Catchmt Area Social Structure	Awareness of Community	Exp. or On-the-job Training			2
COMMUNITY RESOURCES					
Types & Uses of Resources	Training + Experience	Formal Ed. or Training	15	1	3
Availability of Resources	Training + Experience	Formal Ed. or Training	15	1	3
Linking Client to Resources	Training + Experience	Formal Ed. or Training	15	1	3
EVALUATION					
Concepts of Evaluation	Training + Experience	Formal Ed. or Trng. + Exp.	30+	2	2
Measurement Methods	Training + Experience	Formal Ed. or Trng. + Exp.	30+	2	2
OTHER					
Confidentiality	Manual + Exp. (3 Yrs.)	Self-taught			3
			- Successful	Completion of Manual	

## CERTIFICATION FOR VOLUNTEERS

The Addictive Diseases Bureau recognizes the importance of volunteer staff and has created certification standards for volunteers under Class I. This category is to be used for persons who are other than paid, official treatment staff. The classification offers volunteers official recognition in that certificates can be issued declaring persons to be certified volunteers.

Beyond Class I, the volunteer experience does not count. In higher certification levels, II - IV, only paid full time experience can be used because there is no way of validating experience (especially AA related) or of maintaining any quality control on such experience.





